Evaluation of the Chancellor Park Pilot Project

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Prepared by:

Dr. Abraham Ross,
Panacea Research & Evaluation,
and
The Institute for the Advancement of Public Policy, Inc.

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Executive Summary

October 31, 2001 marked the commencement of an agreement between the Department of Health and Community Services (DOHCS), Chancellor Park (CP), and the St. John's Nursing Home (SJNHB) board for the provision of long-term care to Level III and IV residents of Newfoundland and Labrador. The agreement indicated that nursing home subsidies would be provided for 30 residents of CP to assess the feasibility of CP as a new option for nursing home care in St. John's.

Public-private partnership arrangements are commonplace in Canada and the public and private sectors are viewed by provincial governments as equal players in the provision of long-term care. Several reports indicate concerns regarding the quality of care in privately run facilities, however, there was no indication in any of these reports of whether one sector was better or more efficient than the other.

New Brunswick, Nova Scotia, Ontario, and Saskatchewan (whose public-private partnership arrangements for long–term care were reviewed for the present evaluation) employ a mix of for-profit and non-profit models of service delivery for long-term care without distinguishing between the models in terms of subsidization. Regulation and monitoring policies, as well as those pertaining to eligibility of individuals to enter a nursing home, are in place in each province. Each province utilizes different mechanisms to determine the public funding of long-term care nursing operators including the setting of resident fees, as follows: 1) New Brunswick operates from one provincial department with a funding formula based on a nursing home's annual budget requirements; it does not set a maximum provincial per diem rate, 2) Nova Scotia uses a variable annual funding formula to reflect differences in a nursing home's budgeted operating costs and capital needs; it sets a maximum per diem rate for each facility, 3) Ontario regulates an overall provincial per diem rate, allows a differential in resident fees, and employs a service agreement to manage the arrangements, and 4) Saskatchewan relies on its district authorities to manage the arrangements and allows for differing per diem costs and resident fees; it does not set a maximum provincial per diem rate.

Differential methods of determining subsidization rates for operators and annual provincial subsidies are used by these provinces. Three of the provinces use a net operating cost formula (i.e., approved total operating costs less resident fees). In contrast, Ontario distinguishes between the nursing and related care components and the food and accommodation components for a nursing home in setting its per diem subsidy. Ontario fully subsidizes the nursing and related care components and uses a net per diem cost for the remaining components (i.e., residents are only expected to contribute towards the food and accommodation costs of their care to a maximum amount).

Guidelines for the provision of direct resident care varied amongst the four provinces reviewed. Nova Scotia requires the greatest minimum hours of direct resident care at 3.25 hours per resident followed by New Brunswick (2.5 hours) and Ontario (Ontario does not use a particular standard for either registered nurses or the mix of nursing skills, however, information provided for this evaluation suggests that Ontario uses on average between 2.5 and 2.8 hours of direct resident care per day). Saskatchewan uses a guideline of 2.0 hours of nursing care for Level III residents supplemented with other partial hours of nursing care for specific purposes.

There was no significant difference among the provinces in the range of monthly fees in place for long-term care facilities. Health ministries in each of the four provinces set annual budgets for long-term care subsidy funding. The amount of funding available controls the expansion of services.

The public-private partnership agreement developed for the purpose of the current pilot project provided standards to be met by CP for service delivery. Aspects of care included a broad range of service delivery areas including staffing, care, allied health services, medications and nutrition to name a few. The SJNHB was responsible for monitoring CP's adherence to guidelines set forth in the agreement and provided compliance reports for the evaluation. Findings indicate that agreed upon criteria have been met for the majority of guidelines outlined by the agreement, though concerns were raised with regard to admissions, nursing, restorative care, recreational therapy, social work, and maintenance services.

Concerns raised regarding admission proceedures are related to restorative care services and social work services. Specifically, it was noted that there has been a lack of involvement of some disciplines including social work, physiotherapy, occupational therapy and clinical dietetics in the development of interdisciplinary care regiments for the residents. In terms of nursing services, to date CP has been unable to reach the agreed upon 35% LPN staffing ratio. The monitoring reports indicate residents at CP have continued to receive the recommended 3.2 hours of direct resident care. However, due to the multi-skilled nature of the PCAs it was difficult to determine the actual hours of direct care available for residents.

There is currently no designated space available for physiotherapy and occupational therapy services. Although this is not compliant with the standards set forth in the agreement, CP does have space reserved for the future development of physiotherapy and occupational therapy services, and will continue to provide these services on a contractual basis. With regard to recreational therapy services, it was indicated that there are two recreational therapy staff currently employed at CP. The concern raised refers to the fact that neither of these individuals is a recreation specialist and therefore an appropriate assessment is not completed for residents. In terms of social work services, there is currently no Social Worker available to address needs of residents at CP. A Social Worker of SJNHB has been assigned the task of completing financial assessments for residents who are part of the pilot project. The ongoing financial and resource counseling and advocacy role that is usually provided by a Social Worker is currently provided by the administration at CP. With regards to maintenance services, the smoke detectors in Phase I of the building are not connected to the fire alarm system control panel. This continues to be a concern and needs to be addressed if level III and IV residents are to be housed in the unit.

An analysis of clients who have availed of the 30 subsidies indicates little change in the profile of the client group since March 2002, with the exception of a substantial decrease in client mobility levels. Key variables including mean resident age, ratio of male to female residents, primary diagnosis, and average time living at Chancellor Park have not changed during this time.

A major component of the present evaluation was a comparison study of subsidized CP residents with a similar group of residents subsidized at a publicly operated facility. The purpose of this comparison was to compare the two facilities in terms of quality of life, satisfaction with services and residents' happiness. Standardized survey instruments were employed for the comparison, however, it should be noted that the researchers pointed out some limitations to these findings.

One limitation noted was that the majority of residents who had availed of the subsidies were either cognitively impaired or deceased and therefore unable to respond to the survey questions. In such cases the person most knowledgeable of the resident's care (PMK - defined by the individual who visits the resident most frequently) responded on the resident's behalf. Therefore, it is uncertain whether the responses of such individuals is truly representative of the residents' opinions. A second limitation pertains to the fact that residents and family members of CP had a vested interest regarding the outcome of the evaluation. In interpreting the findings of the comparison study, the possibility of biased responses from residents or PMKs of residents living at CP cannot be ignored. A final limitation noted is related to the sizable difference in participation rates of residents and/or PMKs of the comparison facility and those of CP. While the responses of 29 PMKs and two residents of CP were analyzed for the current evaluation, only 15 PMKs and one resident of the comparison facility agreed to participate. The low participation rate of the comparison facility could potentially alter the comparability of the groups and also decrease the likelihood of uncovering statistically significant differences between the samples.

These limitations of the data collected must be recognized in interpreting and utilizing the findings. Despite these limitations, it is still possible to make two important inferences: 1) overall, there appears to be very little difference between the two facilities on all the measures, and 2) when statistically significant differences do emerge, they consistently favor CP.

In addition to quality of life and satisfaction, the evaluation also assessed the quality of care based on findings of monitoring reports and the quality of life and satisfaction surveys employed with residents of both facilities. In addition to concerns previously noted regarding staff skill-mix and the availability of key professionals for interdisciplinary care conferences and consultation, some concerns were also raised with reference to infection rates and medication errors.

Infection rates and medication errors at CP were considerably higher than those at the comparison facility over a seven-month period. Infection rates for CP during that period averaged 18.4%, while those for the comparison facility averaged 10.5%. There were also a total of 38 medication errors reported at CP for 85 residents over an eight-month period. The comparison facility reported one medication error for the same period for 128 residents. For the same eight-month period CP fared better than the comparison facility with respect to the percentage of residents that experienced falls. For CP, falls averaged 25.7%, while for the comparison facility falls averaged 32.5 %.

Representatives of CP and SJNHB questioned the comparability of some of the information discussed in this section (specifically with regard to: 1) meeting the recommended LPN ratio, 2) infection rates, and 3) medication errors). Justifications for the differences between the public and private facilities were provided by CP and SJNHB representatives. These explanations could not be verified without extensive inquiry, and as such are not included here. The reasons for the differences between the public and private facilities should be examined in further research.

Participants in the evaluation were also asked their opinion regarding the addition of CP as a new option for long-term care in the region. The majority of respondents at both facilities indicated they felt that CP should be available to residents of the province needing long-term care. Furthermore, all respondents from both facilities felt that residents should have a choice in the long-term care facility in which they reside. The majority of the comparison facility respondents

felt that there was currently such a choice available; alternatively, the majority of CP respondents stated that there was very little choice available to residents.

In addition to resident and PMK interviews, personal interviews were conducted with key informants representing all key stakeholders (DOHCS, SJNHB, CP management, CP staff, Health and Community Services St. John's Region, and staff and management of the public long-term care system). Interviews revealed that key informants felt the pilot project was beneficial in that it: 1) has permitted CP to retain and gain residents and to be validated within the long-term care system, 2) allows SJNHB to examine a new method of providing care that might be more efficient than the current public system, 3) provides Health and Community Services St. John's Region (HCSSJR) with a new placement option, and 4) allows DOHCS to learn more about public-private partnerships. Challenges regarding the pilot project identified by stakeholders included: 1) the great impact on work load for management of CP and SJNHB, 2) difficulties for SJNHB regarding monitoring and the perception of the public system towards public-private partnerships, and 3) difficulties for HCSSJR in managing the Single Entry System with regards to the project.

A second major component of the present evaluation was an analysis of the cost-effectiveness of such an arrangement for the provision of nursing home care in Newfoundland and Labrador. There are many factors to be considered in the costing data and in comparing the difference in the overall costs including staffing, skill mix, availability of allied health professionals, staff compensation packages, administration, physical condition of the facility, provision for profit, and taxation.

The cost of the pilot project delivered by CP has been determined to be less expensive than the cost of operating a similar number of beds with the same category of residents (Level III) by the comparison facility; this differential is estimated at $1,426 month. This cost differential increases as CP increases its occupancy level as it has the opportunity to allocate its fixed costs over a larger resident (i.e., revenue) base.

Overall, based on the data collected and analyzed for this evaluation, the CP pilot project is determined to be cost-effective in relation to the SJNHB. As a second measure of cost-effectiveness, the results of the comparison of the costs of the pilot project were compared to a proxy cost of delivering nursing home care in the four comparator provinces selected for this evaluation. The proxy cost is defined as the amount of fees charged in these four provinces. In relation to three other provinces (NB, NS and Saskatchewan) - both in terms of the cost comparisons and the quality of care as measured by the hours of nursing care provided - the CP pilot project is assessed to be cost-effective, albeit CP's comparative costs are at the higher end of the range of these other provinces' costs. Only one province, Ontario, has lower comparative costs and the pilot project would not be cost-effective in relation to that province.

Based on the data collected from other provinces and the current cost-effectiveness of the pilot project, there are no identified reasons as to why any future public-private partnership arrangements for long-term nursing care in this province should not also be cost-effective. It is recognized that further analysis will have to be completed by government and its stakeholders taking into account such significant factors as the cost of land and building construction, and employee compensation costs based on required skills and remuneration rates before such an arrangement is contemplated.

This evaluation provides a wealth of information regarding various aspects of the CP pilot project along with quality and cost comparisons to SJNHB. As well, it provides a better understanding of the design and funding of long-term nursing care services in four other provinces. From the review of various current reports and studies on the topic of nursing home care, some of the significant factors that influence effective public-private partnership arrangements in this sector and the quality and cost of care have been discerned. Recommendations were made by the evaluators around the development of clear monitoring guidelines and further analysis of outstanding issues in the areas of skill mix, infection rates, medication errors, systematic review of roles and responsibilities, ongoing evaluation and open communication with residents and their families.

In addition to these overall recommendations, a number of potential implications for other similar public-private arrangements for the provision of long term care in Newfoundland and Labrador were identified by the consultants. Throughout the course of the evaluation it became apparent that it is a common misconception that in other Canadian provinces, residents are subsidized and then choose the nursing home in which they wish to reside as opposed to the facilities receiving a subsidy. Actually, this is not in fact the case; individuals generally have a limited choice as to which home they enter which is independent of the subsidy arrangement and this needs to be communicated. A centralized entry system is viewed as an important component of access to long-term nursing care in the provinces reviewed for this evaluation. Newfoundland and Labrador has a recognized single-entry system; this system should be retained as the basis for any individual availing of a nursing bed funded under any future public-private partnership arrangements.

It was also noted that the provincial government would be expected to subsidize any similar arrangement; this will require that the government dedicate sufficient funds to meet this cost. In terms of how government might fund similar arrangements, two potential options have been identified: 1) use of a standard funding formula that applies to all homes, or 2) use an operating cost deficiency model that allows for different subsidies for different nursing homes. In addition to funding, other roles, responsibilities and guidelines for DOHCS and the Regional Boards in the negotiation and management of a similar arrangement with a private operator will have to be further refined. There is no definitive means to arrive at the appropriate relationship but it must be clarified and understood by the various stakeholders at the outset.

Guidelines concerning resident fees will also be necessary for any similar arrangements. A number of possibilities were salient from the findings of the evaluation: 1) similar to the process currently in use by CP, a standard fee schedule with fees to cover all of the costs is a possibility (however, this raises the matter of the ability for most residents to cover this cost), 2) use of a standard fee schedule with fees to cover specified components of the costs which makes the fee schedule relevant to residents' capacity to pay, or 3) use of a variable fee schedule based on either the operating cost of a facility and/or residents' ability to pay.

Any future public-private partnership arrangement for nursing home care has to lend certainty to the individual resident who avails of the bed and is concerned about movement between facilities, the operator of the facility who has a significant investment in the arrangement, and the staff who work with the facility. The result of adhering to these requirements is that any future arrangement has to be of a long-term duration.

The pilot project was managed through an agreement that also specifies standards and accountabilities. Regulation of the provision and monitoring of public-private partnerships (with both for-profit and non-profit homes) in other provinces reviewed for this evaluation is defined by a mix of legislation, regulations, departmental policies, guidelines, agreements and other arrangements. This province may need to consider if a legislated regime is necessary or if negotiated agreements for the provision and monitoring of nursing home care in the province are acceptable. Any legislated approach should be applicable to all operators (for-profit, non-profit operators and public facilities). Further assessment of legislation and policy regimes concerning the delivery of nursing home care in place in other provinces should be conducted to identify best practices to form the basis of a comprehensive policy approach and funding regime for any future public-private partnership arrangements for this province.

In addition to further analysis of practices in other provinces, the Province can build on the lessons learned from the current pilot project arrangement to better define its requirements and compliance processes for any future similar arrangements. As a party to public-private partnership arrangements, public agencies should not impose a higher standard than they themselves are able to meet; they should encourage innovation and flexibility so long as the overall objective of an acceptable level of resident care in a secure and comfortable environment is provided.

Introduction[1]

Background

The population of Newfoundland and Labrador has, in the past, been younger than that in other provinces. However, recent census information shows increases in the rate the population of this province is aging, particularly in the cohort of individuals over the age of 75. Not only is the population aging as a result of out-migration and a decrease in births, but seniors are also living longer and are healthier than in the past. This raises concerns about how services will be provided to the aging population.

Long-term care residential accommodations for seniors are currently provided by personal care and nursing homes in this Province. Personal care homes are a private-for-profit industry that offer care and accommodations for persons with low care needs, i.e., Level I and II. Nursing homes are primarily publicly owned and operated and provide services to persons with high care needs. While some nursing homes are institutional looking, others offer homelike amenities similar to personal care homes. There are seven nursing homes in the St. John's region - Chancellor Park (CP) and six facilities operated through the St. John's Nursing Home Board (SJNHB). Five SJNHB facilities are owned by religious/fraternity groups and one facility is government owned. These six facilities are publicly funded. Chancellor Park is a private for-profit-facility.

Chancellor Park

CP, a 188-bed facility owned by Progress Homes Incorporated, initially opened its doors April 1, 1993 as an independent living facility with a personal care home license for one floor. Previously, CP was a personal care home serving a clientele requiring level I and level II care, but as clients aged the owners decided they would attempt to meet the needs of residents requiring higher levels of care. Thus, the facility took steps that would allow them to operate as a nursing home facility. In 1996 CP was accredited by the Canadian Council of Health Services Accreditation as a nursing home.

All residents initially entered CP as private paying individuals. As some residents exhausted their personal funds, they sought assistance through public funds to remain at CP. These individuals applied for, and received, home support subsidies. The care needs of many individuals subsequently changed from low to high. These residents then required nursing home level care but still wished to stay at CP. All parties had to determine how best to provide these individuals with higher level care and be respective of their desire to remain at CP. The solution arrived at was to enter into a one year pilot project with CP for the provision of nursing home care to 30 residents.

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[1] Information from the introduction was taken largely from the Phase I evaluation.

Use of Public-private Partnerships for the Provision of Nursing Home Care in Other Jurisdictions

Based on information received from other provinces and territories, the private industry (both for-profit and not-for-profit) appears to play a significant role in both residential and nursing home care across the country (the use of such public-private partnership agreements in other jurisdictions will be discussed in more detail later in this report).

From an international perspective, Alberta's Long-term Care Review (1999) found that in countries like the Netherlands, Sweden, and Australia there was:

- A declining focus on building institutions. Clients are only admitted to facilities when their care costs in a home living environment become prohibitive.
- Service options, subject to client choice are available independent of the housing arrangement.
- More funding flowing to individuals and moving with individuals giving them the choice in their service selection.
- An increasing array of community service providers either through public or private home care organizations are available, introducing an element of competition and increasing focus on quality of services
- An increasing reliance on the private sector for the housing component.

Need for Nursing Home Care in the St. John's Region

The Clinical Epidemiology Unit of Memorial University of Newfoundland has conducted research to look at the current and anticipated need of long-term care beds in the St. John's Region. They found that the need over the next ten years in the St. John's region was not for more high level nursing home beds (i.e., levels III and IV) but rather for lower level personal care home beds (i.e., levels I and II). An estimated 20% of all nursing home beds are currently occupied by residents who require low levels of care and whose needs could be better provided for in supervised care, either in a personal care home or through home support. This could open a higher number of beds for clients who require higher levels of care. Based on this and regional population projection figures, predictions were made as to the number of long-term care beds needed in the St. John's region by 2011. This analysis revealed, assuming that the current facilities are 'suitable,' a surplus of nursing home beds in the St. John's region over the next ten years.

Thus, the issue is not a question of whether there is a need for additional nursing home beds, but rather, a question of whether the facilities currently available are suitable for the provision of high level care (i.e., levels III and IV). Recent reviews within the St. John's Nursing Home Board (SJNHB) have revealed that substantial capital cost expenditures are necessary in order to bring the current facilities up to acceptable standards. Areas of concern involve bedroom sizes and capacity, washrooms, and support spaces. There are also concerns regarding structural renovations to address such things as leaky roofs, windows and exterior walls, indoor air quality, the institutional layout and environment and accessibility issues to name a few. Many facilities are also not adequately structured for higher levels of care.

The Pilot Project

In October 2001, the Department of Health and Community Services, Chancellor Park, and the St. John's Nursing Home Board entered into an agreement to conduct a one-year pilot project for the provision of 30 subsidized beds for levels III and IV care at Chancellor Park. Included in the pilot project was the provision of nursing home subsidies for these 30 beds. This project was to be retroactive to April 1, 2001 and continue until March 31, 2002. Twenty-six of the residents to be subsidized were already residing at CP at the commencement of the pilot project and the remaining four subsidies were allocated to individuals waitlisted for nursing home placement through the Single Entry System of Health and Community Services St. John's Region (HCSSJR).

Arrangements were made for subsidies for the 30 beds to be paid through the SJNHB. The maximum subsidy amount is $4800 and was reduced if the individual had the ability to pay a personal contribution, as determined by SJNHB using long-term care guidelines. Monitoring, auditing, and review of all matters pertaining to services provided by CP for these 30 residents is the responsibility of SJNHB. For the duration of the project, CP was to provide the usual attendant care and professional services (including professional nursing services, which must be available on site 24 hours daily) for these individuals and to follow the guidelines for standards of care and other criteria, as set out in the agreement.

Phase I Evaluation

While the initial pilot project was a one-year pilot from April 1, 2001 to March 31, 2002, it was realized that it was not feasible to conduct an in-depth evaluation prior to March 31st, as all processes had not been in place long enough to obtain thorough data. Therefore, a two-phase evaluation was deemed necessary, with the second phase involving a more in-depth analysis. The initial phase provided preliminary information on:

- Compliance with the standards/criteria set out in the agreement;
- Preliminary data on client profile;
- Preliminary data on staff complement and hours of care;
- Preliminary analysis of quality of care;
- The cost-effectiveness of the project to date and anticipated long-term cost effectiveness;
- Financial accountability;
- The effectiveness of the partnership among all parties in the agreement;
- Short term impacts of the agreement on all parties; and
- Recommendations

One of the recommendations of the initial evaluation was that over the following year a more comprehensive evaluation of the pilot project be conducted. It was suggested that an outside consultant contracted to DOHCS conduct the second evaluation. This recommendation was followed up on and led to the present evaluation report.

Phase II Evaluation

The Evaluation Steering Committee for the CP pilot project includes representatives of DOHCS, CP, SJNHB, and HCSSJR. These individuals developed an evaluation framework for the project and DOHCS selected the consultants to complete the evaluation. A key aspect of this evaluation is that it was completed with a high degree of collaboration between the consultants and the Evaluation Steering Committee, allowing the evaluation to occur efficiently and effectively.

To complete the evaluation of the CP pilot project, two groups of professionals were chosen to collaborate on various aspects of the evaluation. Under the direction of project manager Dr. Abraham Ross key components of the research were completed by Panacea Research & Evaluation, and The Institute for the Advancement of Public Policy. Both organizations are independent firms operating within the province of Newfoundland and Labrador. The evaluators did not have any biases in the area and were free of preconceived preferences or allegiances; as such, it was possible to complete an objective evaluation of the CP pilot project.

Method

This section briefly outlines the evaluation design and methods used in the evaluation of the Chancellor Park pilot project.

I. Key Informant Interviews

Personal interviews were conducted with all individuals who were identified by members of the Evaluation Steering Committee as key informants. Representatives of DOHCS, SJNHB, HCSSJR, CP, and the comparison facility were interviewed. The evaluators conducted all personal interviews either by phone or face to face. All interviews were audio taped and later transcribed.

II. Facility Comparison

Participants:

Overall, 40 individuals had availed of the nursing home subsidies at CP prior to the commencement of the present evaluation. For the purposes of the evaluation, a similar group of 40 individuals from a comparison facility was selected by SJNHB to constitute a comparison group. When a resident was deemed cognitively well enough to participate, every effort was made to interview the individual. However, the majority of residents from both groups were cognitively impaired. Where the individual was cognitively impaired, or deceased, the person most knowledgeable (PMK) of the individual was asked to provide insight regarding the quality of life, satisfaction with care, and happiness of the resident.

Due to attrition and participation refusals, the original sample of selected respondents was reduced considerably. For CP the final sample included 31 PMKs and two cognitively well residents. At the comparison facility, the final sample included 15 PMKs and one cognitively well resident. In the two cases from CP where both the resident and the PMK participated, the data from the resident themselves was used for the analysis, as this data is probably more valid than inferences made by the PMK. Thus, the final sample for CP included 29 PMKs and two residents for a total of 31 participants, and the comparison facility sample consisted of 15 PMKs and one resident for a total of 16 participants.

Measures:

Quality of Life

The Quality of Life (QOL) measure that was selected for the present evaluation includes items to assess both QOL and quality of care (Kane et al., 2000). There are 11 QOL domains assessed by this measure; further, the measure includes 12 summary questions, which cover each of the 11 domains and also general quality of life.

Service Satisfaction

A measure of satisfaction with nursing home care that was developed by another consultant for use at the St. Patrick's Mercy Home was utilized to assess how satisfied the respondents were with the care provided.

MUNSH

The Memorial University of Newfoundland Scale of Happiness (MUNSH: Kozma, 1983) was used to determine if there were differences in the happiness of the residents at CP and the

comparison facility.

Additional Questions

Respondents were asked about a number of issues related to the pilot project including additional costs, access to home of one's choice, and the addition of CP as an option for nursing home care.

Findings and Discussion

This section of the report is organized around the 13 content areas developed by the Evaluation Steering Committee.

I. Public-private partnership arrangements in other provinces.

In consultation with the Evaluation Steering Committee, the consultant selected four Canadian provinces to examine for public-private partnership arrangements to deliver nursing home care in their jurisdictions. The provinces of New Brunswick and Nova Scotia were selected because of their geographical proximity, their comparable population sizes, and their comparability to Newfoundland and Labrador in the delivery of health-related services. Ontario was selected because of its heavy dependence on the private sector to deliver nursing home care services. Finally, a western province, Saskatchewan, was selected for its comparable population size and comparability in the delivery of health-related services.

For the purpose of this evaluation, public-private partnership arrangements are defined as approaches to service delivery by which the public sector facilitates the growth of the private sector and harnesses private sector resources to achieve a specific development objective (as defined in The Commonwealth Portfolio). Based on the research completed for this evaluation, this definition can be applied to the delivery of nursing home care services in the four provinces selected. In these cases, the nature of the public-private sector arrangement is generally understood to mean the basis by which provincial governments support by regulation and/or funding the delivery of these services by, or in collaboration with, private nursing home operators, both non-profit and for-profit based.

New Brunswick

The New Brunswick Department of Family and Community Services funds a long-term care program with the objective of providing services to those individuals who require assistance to carry out normal daily activities. As part of this program, residential services in nursing homes are available to individuals when staying at home is not a viable alternative for them. Individuals are given both a health assessment and a financial assessment by the Department to determine eligibility for placement and financial assistance, respectively. Individuals have the choice as to which nursing home they enter; however, when a second placement is refused, an individual can be removed from the waiting list.

New Brunswick has over 4,100 nursing home beds delivered in 61 nursing homes of which one is operated as a for-profit home. These homes are regulated through the Nursing Homes Act and Regulations along with departmental standards and policies. The fees charged by these homes range from $3,800 to $5,000 per month. Approximately, 82 per cent of the residents in New Brunswick's nursing homes require a government subsidy.

The New Brunswick Department provides financial assistance to those individuals who are

unable to pay the full cost of these services. A provincial subsidy is available to individuals based on the differential between the fees charged by the nursing homes and their contribution. This results in the subsidy equating to, on average, between $120/day to $125/day, or up to $3,750 a month for an individual. In fact, the Department funds each nursing home based on the home's approved budget at the beginning of each fiscal year. The budget may be adjusted throughout the year if additional expenses, such as wage increases, come into effect after April 1. A nursing home may also receive a grant of up to $100,000 for equipment and major repairs.

There is no distinction made by the Department between the non-profit and for-profit homes for the placement of individuals or when allocating the subsidies in support of their care. Each home is inspected on a regular basis.

Currently, nursing homes have to provide a minimum of 2.5 hours of nursing care daily for each of their residents. The home's application of the Department's nursing staffing guidelines and the funding allocated for this staffing is monitored through its annual inspection process and through random audits by the Department.

Nova Scotia

The Nova Scotia Department of Health has a long-term care program under which it provides housing and care for eligible seniors in nursing homes or homes for the aged. The government inspects and licenses the homes, sets budgets and per diem rates that vary by a home's operating costs and capital requirements. It also develops and administers laws and policies related to nursing homes in the province.

Individuals are expected to pay the full costs of their housing and care if they have the means to do so. For those who are eligible for care as determined by the Department of Health through its single entry access system and cannot pay the full costs, financial assistance is available. In these cases, the individual is assessed for financial assistance by the Department of Community Services; as well, that Department co-ordinates admissions to nursing homes. Individuals name a preferred community and home and are placed on a waiting list for that home. In cases where an individual is in a hospital and waiting placement in a home, the individual can be placed within 100 km of their preferred choice of a home when discharged (i.e. on a first-available-bed basis).

There are 6,000 nursing home beds in 70 nursing homes in Nova Scotia. There are three types of nursing homes: (i) private homes operated for profit, (ii) private homes operated for non-profit, and (iii) municipally-operated homes. These homes are regulated through the Homes for Special Care Act and Regulations as well as by Department of Health policies. Approximately, 80 per cent of individuals in these nursing homes are subsidized by the Nova Scotia Department of Health.

The Nova Scotia Department of Health sets the fee that a nursing home can charge individuals. This fee is determined after the home submits a business plan that itemizes the home's operating and capital costs, its occupancy rate and the cost of any additional services its provides. Provincial subsidies for each home take the form of an annual budget based on resident needs, the number of staff (FTE's), and the level of care required.

For nursing homes offering nursing care for an individual with a classification equivalent to a Level III in Newfoundland and Labrador, the fee charged an individual ranges from $110/day to

$199/day, with the average fee equal to $139/day or $4,228/month. There is no distinction made between the various types of nursing homes for which this rate is charged and the basis on which the provincial subsidy is calculated.

The Nova Scotia Department licenses each home, which must meet minimum standards. There is no regulated standard for nursing care though the consultant was informed that it is equal to 3.25 hours of care daily for each resident. There is an annual inspection of each home that includes monitoring of the services provided, interviews with staff and a review of resident files.

Ontario

The Ontario Ministry of Health and Long-Term Care provides funding under its Integrated Health Care Program. This is a program for long-term care facilities to provide care and services to individuals who are unable to live independently at home and who require the services of a nursing home. In Ontario, provincially funded and regulated long-term care facilities fall into three categories: (i) nursing homes, (ii) municipal homes for the aged, and (iii) charitable homes for the aged. The Ministry's focus is to ensure that nursing home operators deliver the services in accordance with the service agreements they sign with the Ministry.

There are three pieces of legislation and associated regulations that specify requirements for admission, the care that is provided, the rights of residents, the responsibilities of the facilities and the obligations of the Ministry. Nursing homes are licensed by the Ministry to operate a specific number of beds for each facility; there are no licensing requirements for municipal and charitable homes.

Homes for the aged are approved to operate their beds under a budget arrangement with the Ministry; these homes as well as the charitable homes must conform to Ministry standards.

Admissions of individuals to long-term care facilities are arranged by the Ministry's province-wide mandatory placement co-ordination system (43 Community Care Access Centres) based on a health care assessment conducted of the individuals by a health practitioner.

There are approximately 60,000 residents in 558 long-term care facilities in Ontario. In the nursing home category, 10 per cent of the homes are operated by non-profit organizations with 90 per cent operated by the private sector. All operators are required to have a signed service agreement with the Ministry. This agreement specifies the facility's budget, the programs and services that are to be provided by the operator, and the provincial subsidy to be provided, among other provisions.

Funding for all private and non-profit long-term care facilities is provided through four distinct per diem fees that are set by regulation. For individuals requiring an average level of care, the overall fee is $110.73 that consists of a nursing and personal care per diem rate of $59.81, a program and support services per diem rate of $5.35, a raw food per diem rate of $4.49, and an other accommodations per diem rate of $41.08. The per diem fees are the same for all facilities except for the nursing and personal care component that is increased based on a specific higher assessed case mix measure for a particular facility. The Ontario Ministry pays for the nursing and personal care and program and support services per diem fees. The individual resident is responsible for the balance of the fees. As well, individuals can be charged an additional $8 daily fee for a semi-private room and an $18 daily fee for a private room.

In Ontario, additional provincial subsidies are also provided as follows:

- An amount of $0.33 per resident per day is paid to long-term care facilities that are accredited,
- An amount of up to $10.35 per resident per day is provided by the Ministry in operating funds to support the payment of loans secured to pay for capital costs of new or renovated beds,
- Any revenue that an operator receives from its preferred-accommodation per diem is retained by the operator and is not shared with the Ministry (as was done previous to January, 2001), and
- Each facility receives a reimbursement by the Ministry in an amount equal to 90 per cent of the municipal and capital taxes it pays (subject to an overall cap on a provincial fund for this purpose).

The potential range of operating costs for nursing homes in Ontario is calculated between $3,368/month to $4,240/month for a facility with an average assessed case mix measure as determined by the Ontario Ministry.

As noted above, the individual resident of a long-term care facility makes a co-payment towards the accommodation and food costs components of their per diem fee to a maximum of $47.53 per diem adjusted annually based on changes in OAS/GIS payments. This fee is the same throughout Ontario and is regulated by the provincial government. It will be increased to $51.53 during 2003. If individuals do not have sufficient income, they can apply for a rate reduction that is dependent on their income. Any difference in the amount paid by individuals and the basic accommodation fee charged is made up by the Ministry. This amount is in addition to the nursing and personal care and program and support services per diem fees that the Ministry pays.

The Ministry monitors the quality of care provided to residents as well as the overall operation of each nursing home under its Compliance Management Program. This program directs the conduct of annual inspections of all homes, other specialist inspections and the investigation of complaints to ensure compliance with the province's legislation and regulations, service agreements and/or licenses. The Ministry does not regulate either the staffing requirements, the registered nursing care required or the nursing care staff mix for either type of long-term care facility. The Ministry does not have any standards pertaining to nursing staffing levels or levels of nursing care to be provided for nursing home residents. Information supplied for this evaluation suggests that Ontario nursing homes provide between 2.5 to 2.8 hours of nursing care per day for each resident.

Saskatchewan

The Saskatchewan Health Department provides a Special Care Homes program that is targeted at individuals who have health care needs that cannot be met in the community. Special care homes provide a residential care environment for individuals, primarily seniors, who are deemed eligible. These homes are licensed under the Housing and Special Care Homes Act. District health boards are responsible for establishing a process for determining need for placement and admitting individuals into these homes. The district boards may operate a special-care home directly or through an affiliation or contract arrangement. The Saskatchewan Health Department indicated that there are 187 homes in this category.

There are 8,643 special care beds in Saskatchewan; six homes are operated by the private sector. Both private homes and public agencies are treated the same by the district boards in providing subsidies under individual affiliation agreements.

Provincial funding is determined based on the difference of approved operating costs as determined by the average cost for special care facilities in a district (approximately $4,600 per month) less the individual resident's contributions. Residents' fees that are charged range from a minimum fee of $828/month plus 50 per cent of any income they have above $994/month to a maximum of $1,561/month, with these fees indexed to any increases made in OAS payments.

The district boards use guidelines for determining the level of nursing care provided in a facility. The boards require 2.0 hours of nursing care for Level III category residents and may approve an additional 15 minutes/day for administrative nursing, an additional 30 minutes/day based on acuity for 25 per cent of a facility's residents, and another 30 minutes/day for residents in specialized units. The homes are monitored for quality of their delivery of services by the district boards' program staff.

Findings based on a comparison of the four provinces

The key findings to be drawn from the overview of the four selected provinces' arrangements for long-term nursing care are presented as follows:

1. Each of the four provinces employs a mix of for-profit and non-profit operators to deliver long-term nursing care services with no distinction made between the for-profit and non-profit sectors by the department or ministry involved in regulating and/or subsidizing their operations.
2. Each province has legislation in place to regulate nursing homes supplemented with regulations and departmental policies and standards for the provision of care and monitoring of facilities, with each province having different monitoring and enforcement processes that it employs.
3. Each province has a form of central assessment/screening process to determine eligibility to enter a nursing home.
4. Each province utilizes different mechanisms to determine the public funding of long-term care nursing operators including the setting of resident fees, as follows:
   - New Brunswick operates from one provincial department with a funding formula based on a nursing home's annual budget requirements; it does not set a maximum provincial per diem rate.
   - Nova Scotia uses a variable annual funding formula to reflect differences in a nursing home's budgeted operating costs and capital needs; it sets a maximum per diem rate for each facility.
   - Ontario regulates an overall provincial per diem rate, allows a differential in resident fees, and employs a service agreement to manage the arrangements.
   - Saskatchewan relies on its district authorities to manage the arrangements and allows for differing per diem costs and resident fees; it does not set a maximum provincial per diem rate.
5. The provinces are different in how they determine their annual provincial subsidies; three of the provinces use a net operating cost formula (i.e. approved total operating costs less

resident fees). In contrast, Ontario distinguishes between the nursing and related care components and the food and accommodation components for a nursing home in setting its per diem subsidy; Ontario fully subsidizes the nursing and related care components and uses a net per diem cost for the remaining components (i.e. residents are only expected to contribute towards the food and accommodation costs of their care to a maximum amount).

6. Each province is different in prescribing the daily hours of nursing care to be provided in a nursing home facility, as follows:
   - New Brunswick requires each operator to provide a minimum 2.5 hours of nursing care per resident.
   - Nova Scotia requires the operators to employ 3.25 hours of nursing care per resident.
   - Ontario does not use a particular standard for either registered nurses or the mix of nursing skills; information provided for this evaluation suggests that Ontario uses 2.5 to 2.8 hours of nursing care on average.
   - Saskatchewan uses a guideline of 2.0 hours of nursing care for Level III residents supplemented with other partial hours of nursing care for specific purposes.
7. There is some but not a significant difference in the range of fees, exclusive of any provincial subsidies, in place for long-term care facilities among and within the provinces:
   - New Brunswick's fees range from $3,800/month to $5,000/month.
   - Nova Scotia's fees range from $3,346/month to $6,053/month.
   - Ontario's fees range from $3,368/month to $4,240/month with these fees marginally higher for facilities that provide a higher than average level of nursing care.
   - Saskatchewan's fees average between $4,250/month and $4,600/month.
8. All four provincial governments have set annual budgets for the funding of subsidies for nursing home care that are administered by their respective departments of health or similarly-mandated health ministries. Expansion of services by existing nursing homes or through new entrants is controlled through the availability of budgeted funding.

Results of any evaluations and/or cost-effectiveness analyses conducted

There has been little written on the subject of the cost-effectiveness of public-private partnership arrangements in the delivery of long-term nursing care in Canada. No specific evaluation reports on this topic, especially in the four provinces selected, could be supplied from these provinces during the course of this evaluation. It should be noted that this evaluation did not complete a full-scale literature review; instead, it specifically emphasized the reporting of any evaluations or cost-effectiveness analyses studies in other provinces (for purpose of this evaluation, they are New Brunswick, Nova Scotia, Ontario and Saskatchewan).

What has been written in the literature in recent years that is relevant to this evaluation focuses on quality of care issues including comparisons between private for-profit and non-profit operators, based largely on United States studies, and the nature of public-private partnership arrangements in the delivery of public services generally. Some examples from some current reports and studies that are representative of discussions on the topics being addressed in this evaluation are presented here along with a brief reference as to their relevance to the CP pilot project.

1. A 1998 study (Harrington, Woolhandler, Mullan, Carrillo, & Himmelstein) reported in the

American Journal of Public Health concluded, based on the finding that private operators provide less nursing care than do non-profit operators, that investor-owned (i.e., private) nursing home facilities deliver lower quality care than do non-profit or public facilities. This study was based on an analysis of reported deficiencies in quality of care in 13,693 facilities that receive federal Medicare or Medicaid payments in the United States.

The relevance of this study for the evaluation of the pilot project is that the study tied levels of nursing care to levels of quality of care in a nursing home. Another conclusion that might be drawn from this study is that if levels of nursing care are equal then a private for-profit home can deliver equal quality of care in comparison to a publicly funded nursing home. In the CP pilot project, levels of nursing care are equal to the public system, though there is a difference in the nursing skill mix used.

2. A paper, prepared by Michael Rachlis in November, 2000 for a joint publication of the Canadian Centre for Policy Alternatives - BC Office, the BC Government and Service Employees' Union, the BC Nurses' Union, and the Hospital Employees' Union (BC), outlined some findings on levels of care and costs between private and non-profit long-term care facility operators. The paper presented the results of an examination of 43 peer-reviewed, comparative studies (predominantly United States-based) of long-term residential care. The literature found that non-profit long-term care facilities provided higher or equal quality of care to that provided by for-profit facilities.

   In terms of comparing costs of care, of the 14 studies that he reviewed on this topic, thirteen of the studies demonstrated that for-profit direct institutional care costs less per patient day than non-profit care, while the other study showed no difference in costs. Rachlis suggested that other health care costs have to be included to provide a 'wide-angle view' of long-term care cost comparisons that would result in offsetting the favourable for-profit cost comparison. As well, the studies showed that the basis of the lower costs in for-profit facilities was due to lower staffing costs, either from a lower and/or less trained nursing staff mix and/or lower compensation costs.

   The points to be drawn from the paper for this evaluation is that private for-profit nursing home operators are able to provide the same levels of nursing care generally at lower cost largely because they have lower human resource costs. The basis of these lower costs, namely lower or different nursing and other staff mixes and lower compensation costs, are relevant to the CP pilot project.

3. A 2001 study by PricewaterhouseCoopers to review levels of service and responses to need in a sample of Ontario long-term care facilities and selected comparable jurisdictions in Canada, the United States and Europe found that Ontario's long term care facilities generally had lower nursing and therapy services. This study was conducted for the Ontario Association of Non-Profit Homes and Services for Seniors and the Ontario Long Term Care Association to review the provision of facility-based long term care services in Ontario.

   The relevance of the study to this evaluation is that Ontario's nursing care services for nursing homes are below those in this and other provinces selected and its per diem rates reflect this. *(Reader's note: The Ontario Government increased per diem fees to operators for nursing, personal care and program and support services in 2002).*

4. The Provincial Auditor of Ontario reported in 2002 that the Ontario Ministry of Health and Long-Term Care did not have all the necessary procedures in place in certain significant respects to ensure that their resources for long-term care are managed economically and

efficiently. The Provincial Auditor also found that the facilities were not complying with the applicable policies. The Provincial Auditor noted that the Ministry had not developed either standards to measure the efficiency of facilities in providing quality care or models for staff mixes for providing nursing and personal care. The Provincial Auditor concluded that the Ministry did not have sufficient basis for determining appropriate levels of funding.

The relevance of the Ontario Auditor's report for this evaluation is that despite a compliance management program for nursing homes, the ability of government to effectively monitor these facilities and the services provided is questioned. In this situation, there was no distinction made between the monitoring of privately operated and non-profit homes. The agreement authorizing the CP pilot project has specified various standards of service and a monitoring component.

5. A 1999 Tokyo conference, Public-Private Partnerships in the Social Sector, sponsored by the Asian Development Bank Institute, found that more focus needs to be placed on the potential for public-private partnerships as a new tool for development. Conference participants noted that in many countries (the focus being on developing countries) private provision of services is essential as governments are not capable of meeting existing demand. One of the key questions that arose is how to control quality of service with the expansion of the private sector in the health sector. The participants developed a preliminary checklist for successful public-private partnerships, as follows:
    - There must be accountability, monitoring and transparency by both the public and private sectors,
    - Government must ensure sustainable policies,
    - A favourable legal and regulatory framework must be created,
    - Both sectors must commit to the public good,
    - Resources must be shared across both sectors,
    - A common language, understanding and trust must be developed, and
    - It is important to ensure consumer choice, confidence and equal information flows.

The significance of this conference report is that it specifies specific elements that governments should consider at the time they contemplate using public-private partnership arrangements in the delivery of public services in the health sector. The CP pilot project is an example of this type of arrangement and provides some of the same issues that have had to be considered or will need to be considered if this type of arrangement is continued.

In telephone interviews with public officials in the four provinces contacted for this evaluation, the informants commented that their governments do not distinguish in their policies, regulatory frameworks and funding arrangements between private for-profit and non-profit facilities. Generally speaking, both sectors are viewed as long-standing contributors to the delivery of nursing home care in their respective provinces. The prevailing Ontario Ministry's policy and regulatory approach to long term care and the role of the private operator was confirmed by a private Ontario operator as: "...we are privately run, publicly funded".

When asked, informants for this evaluation commented that they have not noticed or they are not aware of a difference in quality or results between the two sectors in the delivery of nursing home care in their jurisdictions. In one case, the Regina District Health Authority official interviewed suggested that the private operators tend to have a higher quality of standards,

systems and policies in place in the management of their facilities.

Findings based on evaluations and other studies

1. Public-private partnership arrangements are commonplace in the provision of long-term nursing care services in Canada as represented by the four provinces studied. None of the provincial governments seem to have a preference for one sector over the other.
2. Within the four provinces selected, government approaches to long-term nursing care services suggest that both the public sector and the private sector are seen (and should be seen) to be equal players by provincial governments in the delivery of long-term nursing care services.
3. General concerns about the participation of the private sector in the provision of long-term care services have been raised in several reports and studies reviewed for this evaluation. These concerns relate to the quality of privately run systems, as evidenced by the US study and Rachlis paper. In the case of the US study, the researchers suggest that standards of care are considered to be closely related to the level of nursing care in nursing homes.
4. At the same time, there is no distinction to be derived from the several reports and studies reviewed for this evaluation or from the interviews with other provinces' officials as to whether one sector effectively achieves better quality of care or is funded more appropriately than the other sector in the delivery of long-term care nursing services in the four provinces selected. The US literature suggests lower costs for US private operators; no general difference in operating costs for private for-profit and non-profit operators has been presented from the four provinces selected for this evaluation.
5. Finally, there is limited availability of current Canadian-sourced reports and studies on the evaluation and cost-effectiveness of public-private partnership arrangements for the delivery of nursing home care.

II. Client profile

Profile of 30 residents of the Phase II Evaluation

An analysis of Chancellor Park residents who were receiving a nursing home subsidy during the time of the Phase II evaluation report (December 2002) indicated that the average age of residents at that time was 86 years and included eight males and 22 females. The most frequent primary diagnosis for the 30 residents was dementia (73%) and the most frequent secondary diagnosis was arthritis (13%). One resident was assessed as requiring level IV care while all others were assessed as requiring level III care, with one being palliative care. Residents varied in terms of mobility levels from being independent (17%), to being confined to a bed or chair (43%).

These 30 residents have resided at Chancellor Park for an average of three years five months (ranging from five months to more than nine years). They have been in receipt of a nursing home subsidy for an average of one year six months (ranging from two months up to one year eight months) and, 17 of them were in receipt of home support subsidies at Chancellor Park prior to receiving the nursing home subsidy. The majority of these 17 residents were assessed as

requiring home support due to dementia (65%). Of the 13 remaining individuals, all entered Chancellor Park through the Single Entry System and began receiving nursing home subsidies upon entry to the facility.

Change in resident profile from Phase I to Phase II of the evaluation

A comparison of client profiles from March 2002 (Phase I evaluation) and December 2002 (Phase II) indicates that the resident profiles have not changed in terms of mean resident age, ratio of male to female residents, primary diagnosis, and average time living at Chancellor Park.

It was noted in March 2002 that the second most frequent diagnosis for residents was coronary disease, while in December, it was found to be arthritis. While all 30 residents receiving nursing home subsidies in March 2002 were assessed as requiring level III care, one resident was assessed as requiring level IV care in December 2002. Between March and December 2002 the number of palliative care residents receiving nursing home subsidies decreased from four to one. In terms of mobility levels, while only 17% of residents were independent in March 2002, 33% were noted to be independent in December of the same year. However, while no resident receiving a nursing home subsidy in March was confined in terms of mobility, an analysis of resident profiles for December indicates 43% were confined to a chair or bed.

The average number of months residents have been in receipt of nursing home subsidies has increased[2]. While in March 2002 a total of 20 of the profiled residents had been in receipt of home support subsidies at Chancellor Park prior to receiving nursing home subsidies, only 17 of the residents profiled in December had received home support subsidies while residing at Chancellor Park. Nine residents had entered into the pilot project through the Single Entry System in March 2002, and an additional four residents had been placed at Chancellor Park through the Single Entry System nine months later.

Finding based on Client Profiles

1. The client group has not changed substantially with the exception that there has been a large increase in the number of clients that are confined to chairs or beds.

III. Compliance with standards

SJNHB was responsible for the monitoring, review and audit of CP with regard to the pilot project. In this regard, the Board's staff made several visits to CP to determine compliance with the standards set out in the agreement. Assessment of compliance with standards was carried out by a SJNHB representative who met with the Administrator and Director of Nursing at CP to review the guidelines and make note of which criteria are being met. Additionally, the Board representative walked through the facility to conduct a visual check of the premises. CP was required to provide statistics to SJNHB for analysis on such aspects of care as medications errors, infections rates, and falls. The pharmacist that is utilized by CP provided information regarding the number of daily medications per resident.

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[2] It should be noted that the comparison facility and CP use different tools for assessing cognitive status and that the noted comparison was conducted using a percentage score calculated for residents at each home.

Since the inception of the pilot project, two compliance with standards reports have been completed. The first report was completed in March 2002 in preparation for the Phase I evaluation report, and the second report was completed in December 2002 for the purpose of the present evaluation. The frequency for monitoring compliance with standards was not formally outlined in the agreement.

The standards set forth in the agreement provide guidelines for a number of aspects of resident care. The Phase I Evaluation indicates that at that time CP had met most of the agreed upon standards and findings of the current evaluation indicate the same.

Compliance with standards were met in terms of resident care services, medical services, environmental standards, laboratory/diagnostic imaging services, laundry and linen services, pharmacy services, resident property, resident care record, medications, nutrition services, assisting or feeding a resident, safety and security, restraint policy, prevention and response to resident abuse, and provision of care in life threatening situations.

Concerns were raised in terms of admissions, nursing services, restorative care services, recreational therapy services, social work services, and maintenance services. Most concerns raised by the reports on compliance to standards pertained to staffing issues.

Concerns raised in the admissions section of the report are related to restorative care services and social work services. Specifically, it was noted that there has been a lack of involvement of social work, physiotherapy, occupational therapy and clinical dietetics in the development of interdisciplinary care regiments for the residents. It was noted that because such services are provided on a contractual basis at CP (which is compliant with standards set forth in the agreement) these professionals are not involved in the interdisciplinary case conferencing for residents (which is not compliant with criteria set forth in the agreement). In nursing homes that are administered by the public system, Physiotherapists and Occupational Therapists are part of the full time staff and are therefore available for consultation during interdisciplinary conferences.

The December 2002 monitoring report indicated that there is currently no designated space available for physiotherapy and occupational therapy services. Although this is not compliant with the standards set forth in the agreement, CP does have space reserved for the future development of physiotherapy and occupational therapy services, and will continue to provide these services on a contractual basis.

With regard to social work services, there is currently no Social Worker available to address needs of residents at CP. A Social Worker of SJNHB has been assigned the task of completing financial assessments for residents who are part of the pilot project. It was noted in the December monitoring report that the ongoing financial and resource counseling and advocacy role that is usually provided by social work is provided by the administration at CP. However, CP has noted that when normalized occupancy stabilizes at a level that requires full time social work services, it is their intention to provide such services to residents.

In terms of nursing services, the December monitoring report noted that the RN:LPN:PCA skill mix at CP was 19:16:65 while the agreed upon skill mix is 17:35:48. Although administration of CP have indicated they are working to reach the 35% LPN staffing ratio, the highest that was achieved was 21% for the month of September 2002. It was also noted that PCAs of CP are multi-skilled workers and therefore perform duties outside direct resident care. The monitoring

reports indicate residents at CP have continued to receive the recommended 3.2 hours of direct resident care. However, due to the multi-skilled nature of the PCAs it was difficult to determine the actual hours of direct care available for residents.

In regard to recreational therapy services, it was indicated by the December monitoring report that there are two recreational therapy staff currently employed at CP. The concern raised by the monitoring report refers to the fact that neither of these individuals is a recreation specialist. This issue was noted in the Phase I evaluation report which states that because there is no recreation specialist an appropriate assessment is not completed for residents.

With regards to maintenance services, an issue raised by the December 2002 report was that smoke detectors in Phase I of the building were not connected to the fire alarm system control panel. This concern was also raised in the March 2002 report, which indicated that the detectors would have to be connected to the main panel if level III and IV residents were to be housed in the unit. According to the December 2002 monitoring report CP staff have noted this discrepancy and will determine an appropriate course of action.

Findings of Compliance With Standards Reports

1. CP is compliant with the standards set out in the agreement pertaining to resident care services, medical services, environmental standards, laboratory/diagnostic imaging services, laundry and linen services, pharmacy services, resident property, resident care record, medications, nutrition services, assisting or feeding a resident, safety and security, restraint policy, prevention and response to resident abuse, and provision of care in life threatening situations.
2. Concerns were raised regarding several aspects of care including admissions, nursing services, restorative care services, recreational therapy services, social work services, and maintenance services.
3. CP has indicated they are addressing concerns raised by monitoring reports in the following ways: 1) space has been reserved for the future development of physiotherapy and occupational therapy services, 2) expressing their intent to provide social work services on site when occupancy stabilizes at a level that can sustain a full time social work position. Specific plans of action have not been defined for reaching the 35% LPN staffing ratio, nor for connecting smoke detectors in phase I of the building to the fire alarm control panel.

IV. Staff complement and hours of care

Changes in Staff Complement and hours of care over the course of the pilot project have been examined by comparing the March 2002 compliance with standards report with the December 2002 report. Overall, there appears to have been few changes over this 10-month period.

The RN:LPN:PCA ratio was 20:17:63 in March and 19:16:65 in December. This represents a reduction in RN positions, a reduction in LPN positions, and an increase in PCA positions. It was indicated that the administration of CP hopes to reach the 35% LPN staffing ratio (such hopes were also noted in the Phase I evaluation). However, to date, CP has not been able to achieve the agreed upon 35% LPN staffing ratio. The agreed upon skill mix should be attained by CP, or should be reevaluated.

With respect to hours of care, the March report stated that the hours of direct resident care per resident day at CP ranged from 2.6 to 4.1 (depending on the unit), with an average of 3.4 hours of direct resident care per day. The December report stated that the hours of care available to residents ranged from 3.2 to 3.8 hours from April to November 2002. This indicates that CP has been meeting and exceeding the provincial staffing guidelines of 3.0 to 3.2 hours of direct resident care daily. However, as noted previously, it is difficult to determine the actual hours of direct resident care given the multi-skilled nature of PCA positions at CP. It should also be noted that CP staff felt there had been no change in their workload or work duties during the past 12 months.

Findings based on Staff Complement and Hours of Care

1. CP is meeting and exceeding provincial staffing guidelines for overall hours of care, however, because PCAs perform duties other than those related to direct resident care, verifying the actual hours of care received by residents is problematic.
2. To date CP has not been able to achieve the agreed upon 35% LPN staffing ratio.

V. Quality of life and Resident Satisfaction

The results of the quality of life and resident satisfaction analysis need to be treated with caution. There are three interrelated issues that could have an impact on these results and the inferences that can be drawn. These are: 1) the use of the PMK as a proxy for the responses of the resident, 2) the validity of CP respondent responses given their stake in the outcome of the evaluation, and 3) the low level of participation within the comparison facility sample. It should be noted that these limitations refer to the quality of the data, not the quality of the measures. The measures that were used for this evaluation are both reliable and valid.

1. Proxy Responses

First we must address the issue of using the responses of the PMK as a proxy measure for the satisfaction and quality of life of the resident. As indicated previously, two pairs of residents and PMKs from CP agreed to participate in the evaluation. No PMK-resident pairs from the comparison facility agreed to participate in the evaluation. One resident of the comparison facility was interviewed, however, the PMK for this resident did not wish to participate in the evaluation. By comparing the responses of the two CP residents to those of their respective PMKs, we get some idea about the extent to which the PMK ratings are representative of the views of the resident. With respect to the QOL measure, the responses of the resident and PMK were associated to a degree that is statistically significant. With respect to the satisfaction measure, there was a statistically significant relationship between the ratings of one resident and PMK, however there was no relationship between the ratings of the other resident and PMK. With respect to the MUNSH, there was a statistically significant correlation between the responses of both resident-PMK pairs. These findings suggest that generally the responses of the resident and the PMK are similar. The lack of agreement between the resident and PMK on the satisfaction measure is likely not overly problematic. It appears that for this pair the PMK had a tendency to rate the satisfaction with service slightly higher than the resident rated satisfaction. Further, there was disagreement regarding satisfaction with social work services. The resident indicated that there were no social work services and as such responses were coded as not

applicable; however, the PMK rated the services of the SJNHB Social Workers.

Even though there appears to be a relationship between the responses of the PMK and the resident, it should be noted that these residents are cognitively well and capable of communicating concerns to their family member. It is uncertain if the responses of the PMKs of residents that are cognitively impaired are representative of what the resident would actually think. However, given that the comparison is essentially limited to PMKs at both facilities, the analysis is valid for the opinions of these individuals.

2. Biased responses

There were many concerns raised by key stakeholders during the course of the evaluation regarding the validity of the responses of CP residents and PMKs. Specifically, it was felt that the residents and PMKs at CP would inflate their responses to ensure that CP received positive ratings, which in turn would allow residents to continue to receive nursing home subsidies while residing at CP. The residents that were receiving the nursing home subsidies as part of the project felt that they had not been informed that it was a pilot that would eventually come to an end. As such, these individuals have experienced much stress and anxiety regarding what might happen when the pilot project is completed.

One way to examine the possibility of bias is by comparing the responses of the PMK for the deceased and the living sample at both facilities. Obviously, the living sample would be more likely to have a vested interest in the outcome of the evaluation as compared to the deceased sample. The results of this evaluation demonstrate that responses of those individuals referring to deceased residents are somewhat different than the responses that refer to living residents. At CP the 'deceased means[3]'are consistently lower than the 'living means[4],' with the exception of three variables. Alternatively, with respect to the comparison facility, it appears that the 'deceased means' are consistently higher than the 'living means,' with the exception of five variables. Although none of the comparison facility differences were statistically significant (most likely because of the small sample size), eight of the CP differences were statistically significant. These were the QOL domains of autonomy, food enjoyment, and security; the QOL summary items dignity, autonomy, security, and individuality; and the satisfaction with care domain of dietary services. There are three possible explanations for this finding: 1) the care at CP has improved since the passing of the deceased group, 2) the PMKs of the living residents are inflating their responses to ensure that CP gets a good rating, 3) There may have been one or two PMKs of deceased individuals that were rather negative in their ratings of CP.

With respect to the first point, it is noted that there has been no indication of an improvement in the quality of care at CP. First of all, the compliance with standards analysis demonstrated that there have been very few changes in the care that is being provided. Second, CP staff reported that there has been no change in their workload or work duties.

Based on the extent to which PMKs of living residents want the pilot project to continue, it is

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[3] 'deceased means' refers to the averaged ratings of the PMKs that were responding for the deceased residents.

[4] 'living means' refers to the averaged ratings of the PMKs that were responding for the living residents that could not respond for themselves. This group also includes the cognitively well residents that participated.

likely that there was some degree of inflation in their responses regarding the resident quality of life and satisfaction with care. Further, their vested interest in the evaluation outcome is indicated by the differences in participation rates between samples. While there was no difference between facilities in the participation of PMKs for deceased individuals (i.e., seven from both sites), three times as many PMKs for living residents participated at CP as compared to the comparison facility (i.e., 24 vs. 8). There are two plausible reasons for this difference. First of all, residents and family members at CP were much more cognizant of the evaluation than were residents and family members at the comparison facility. In fact, the CP sample was informed that the evaluation was happening and that they would be contacted to participate; however, the comparison facility participants were only made aware of the evaluation and their inclusion in it when the evaluator contacted them. This factor certainly contributed to the difference in participation rates. However, if this were the only factor, then one would expect that there would have been a difference in participation rates between the PMKs of deceased residents. The fact that there was no difference indicates a vested interest in the outcome of the project for the PMKs of living residents.

Finally, it is possible that the responses of one PMK regarding his/her deceased family member's quality of life and satisfaction with care might have decreased the means for the deceased sample. While this may have decreased the means slightly, it is not likely that it decreased them to an extent that would have created statistically significant differences.

3. Low participation by the comparison facility respondents.

As indicated above, there was a sizable difference between the participation rates for the CP sample and the comparison facility sample. This decreases the likelihood of uncovering statistically significant differences between the samples, and alters the matching of the members of the two groups. With reference to the first point, it is likely that the small sample of respondents from the comparison facility has prevented the discovery of statistically significant differences between the two facilities on a number of measures. This is compounded by the fact that PMKs at both facilities did not feel capable of responding on behalf of their family member for various variables or indicated that certain questions were not applicable because of the resident's health. This further decreased the sample size for many of the variables. For example, even though the total sample size was 31 for CP and 16 for the comparison facility, the sample of individuals that responded to the domain of functional competence on the QOL measure was 21 for CP and 10 for the comparison facility. Even if there is a difference between the facilities on this domain, the sample might not be large enough to demonstrate it.

Clients at CP who were part of the pilot project were matched with residents at the comparison facility on a number of variables to serve as a comparison group for the purpose of evaluation. While residents were assessed on a variety of variables, it was felt by the evaluation committee that certain variables were of key importance in terms of selecting the comparison group, particularly: 1) age, 2) sex, 3) length of time in long term care facility, 4) primary and secondary diagnoses, 5) placement process 6) level of care, 7) type of care, 8) deceased/living, and 9) cognitive status. Analyses were conducted to assess whether there were differences between groups for these variables for both the original matched set as well as the groups who agreed to participate in the evaluation.

The original groups were similar on age, sex, the amount of time they had resided in a long-term care facility, primary and secondary diagnoses, type of care and whether the resident was living

or deceased. There were statistically significant differences found to exist between groups for placement process, level of care, cognitive status[5], and length of time receiving a nursing home subsidy[6].

The final group of participants from CP consisted of 31 of the 40 subsidized residents, while that of the comparison facility consisted of 16 of the 40 individuals chosen for the comparison group. No statistically significant differences were found between the two groups for age, sex, time residing in the facility, primary and secondary diagnoses, type of care, whether the resident was deceased or living, and cognitive status. There were statistically significant differences found to exist between groups for the variables of placement process, level of care, and length of time resident was receiving a nursing home subsidy[6].

Based on the number of variables on which the original groups and the participating groups were appropriately matched, one could conclude that the participating groups were actually better matched than the originals (i.e., the participating groups are a good match). It should be noted that for the original matched sets of 40 participants, statistically significant differences were found to exist for the residents' percent score on their respective cognitive ability assessments although the participating groups did match on this variable. Of the variables that the Evaluation Steering Committee designated as most important for matching purposes, none that were matched for the original groups of 40 were found to have statistically significant differences for the participating groups. Of the 'other' variables on which information was available for residents of both homes, statistically significant differences were eliminated between the participating groups for four variables that were found to differ between the original groups (feeding ability, total prescriptions provided on as needed basis, need for complex dressing treatment, and visual ability). However, while the original groups had been matched in terms of physically aggressive behavior, statistically significant differences existed between the participating groups for this variable, with residents at the comparison facility tending to be more aggressive.

Questionnaire responses

Despite the low levels of participation by the comparison facility sample, it is still possible to make two important inferences: 1) overall, there appears to be a very small difference between the two facilities on all the measures, and 2) when statistically significant differences did emerge, they favored CP consistently. It should be noted that the responses of individual PMK/residents will not be reported in the discussion that follows. These findings should only be interpreted along with the aforementioned caveats.

Quality of Life

For all measures of QOL, CP rated higher than the comparison facility. With respect to the

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[5] It should be noted that the comparison facility and CP use different tools for assessing cognitive status and that the noted comparison was conducted using a percentage score calculated for residents at each home.

[6] This is expected as residents of CP have only had the opportunity to receive nursing home subsidies since April 2001, while those of the comparison facility would have been eligible for nursing home subsidy since the time they were admitted to the public facility.

domain scores, CP was rated significantly higher on physical comfort, dignity, autonomy, food enjoyment, and individuality. The domain means are presented in Figure 1. Ratings of the summary items of the QOL measure were also consistently higher for CP, as is demonstrated in Figure 2. Those differences that were statistically significant include physical comfort, functional competence, privacy, dignity, meaningful activity, relationships, autonomy, and food enjoyment.

Figure 1: Quality of Life Domains

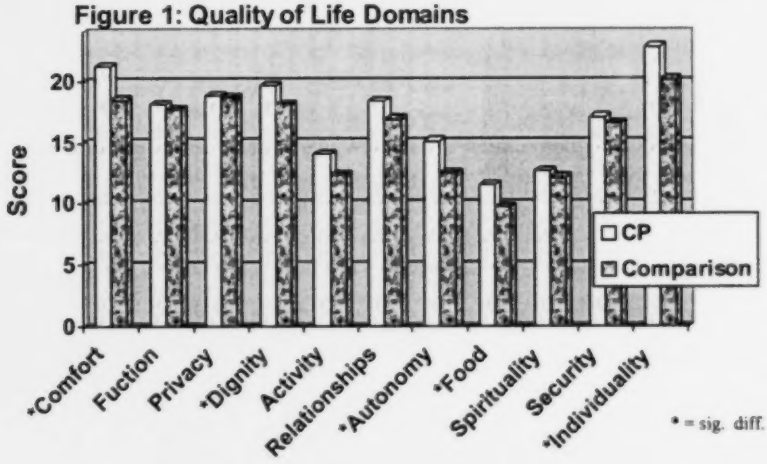
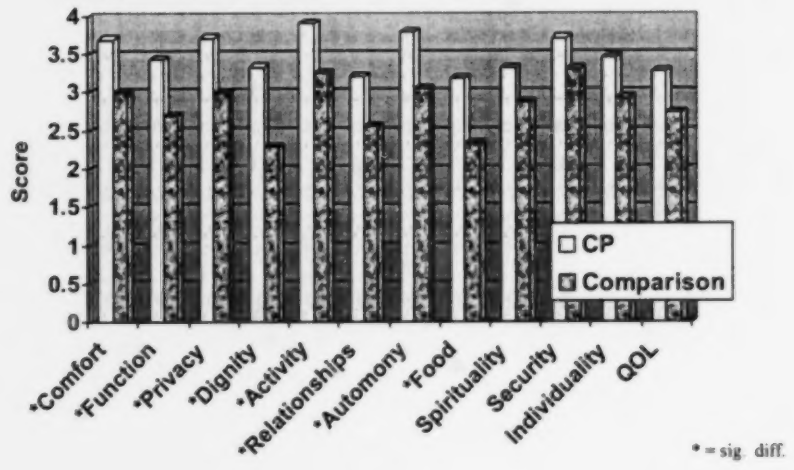


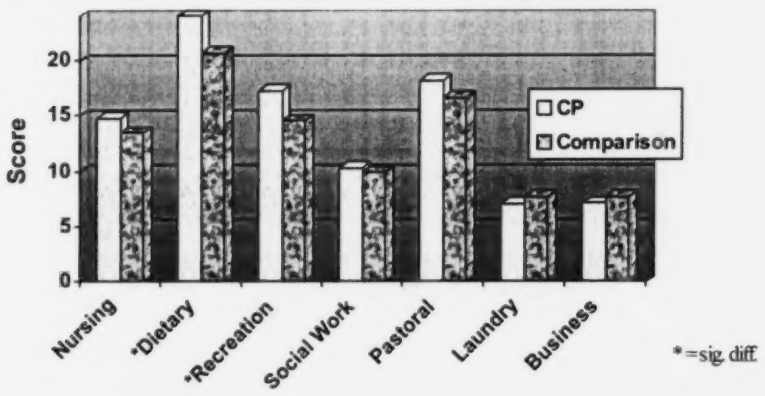
Figure 2: Quality of Life Summary Items



Satisfaction Survey Findings

Findings of the satisfaction survey indicate that CP scored higher on the domains of satisfaction with direct resident care, dietary services, recreation services, social work services, and pastoral care services while the comparison facility scored higher on the domains of satisfaction with laundry and business services. However, it should be noted that only differences in scores for the domains of dietary and recreational services were statistically significant. Figure 3 shows mean scores for each home on the seven domains covered by the satisfaction survey.

Figure 3: Satisfaction with Services



Findings indicate a statistically significant difference in satisfaction with dietary services between the two facilities. Responses to open-ended questions support this difference. Comments made by residents at CP indicate that overall respondents were very satisfied with dietary services at the home. It was noted that there is an excellent variety of food available for meals and snacks and that the serving sizes are appropriate. Several respondents commented that dietary staff ensure meals are reflective of residents' preferences and any special dietary needs resulting from medical conditions. It was noted that staff are attentive to residents' needs, quick to inform family members of issues with residents' eating patterns, and that they make sure residents don't eat too little or too much.

While many respondents of the comparison facility felt that dietary services were adequate, the following suggestions were made with respect to this service at the comparison facility:

1. Increase the availability of fresh vegetables
2. Provide options in type of milk available (i.e., 1%, 2%, whole, skim)
3. Better response to residents' dietary requests
4. Increase portion size
5. More variety in meals

Participants at CP indicated a higher degree of satisfaction with reference to recreational services. Although several respondents of the comparison facility noted that the resident was unable to participate in recreational activities as a result of their medical condition, the majority of respondents felt that there was room for improvement in this aspect of resident care. It was

noted that the frequency and variety of recreational activities available to residents of the comparison facility should be increased. Suggestions included providing more musical entertainment and that a greater effort be made to include residents with cognitive and physical impairments in recreation activities. It was felt that activities should be geared toward residents' likes as well as their abilities.

With reference to recreational services, several respondents indicated that they could not indicate a level of satisfaction, as the resident was unable to take part in organized recreational activities due to their medical condition and/or cognitive abilities. However, respondents of CP made the following recommendations:

1. More organized activities such as musical entertainment, bingo and card games.
2. Increase the frequency of activities
3. More one-on-one time so cognitively impaired residents may be able to participate more.

Although findings indicate a greater level of satisfaction with social work services at CP (although the difference was not statistically significant), this finding needs clarification. CP offers social work services on a contractual basis and few clients of the pilot project had availed of social work services beyond those provided by SJNHB at admission. The majority of CP respondents indicated that the section of the satisfaction questionnaire on social work services was not applicable to the resident, as they had never availed of such services. Therefore, findings regarding this aspect of resident care are based on responses of only seven of 31 CP participants (23%). For the comparison facility, findings of this domain are based on the responses of 12 participants (75%). It should also be noted that most of the CP participants who responded to questions on this domain indicated that they were responding to the survey items with reference to the interactions they had with the Social Workers of SJNHB who were assigned the task of carrying out financial assessments on the residents for the purpose of the project. It is likely that this result is because CP residents were satisfied with the social work services provided during the assessment stage of the pilot project, while the comparison facility participants were satisfied with the ongoing social work services provided at the home.

Overall, few suggestions for change to social work services were made by participants of either facility. The most frequently cited suggestion was to increase the availability of social work services at the facilities. Several respondents of the comparison facility felt that residents' social needs were not being adequately met, but they suspected that this was a result of understaffing as opposed to any fault of the Social Worker's abilities or efforts.

Another difference noted between the two facilities was that a much higher percentage of respondents of CP (83.9%) had participated in interdisciplinary team conferences within the last year than at the comparison facility (50%). All individuals from both facilities that had participated in an interdisciplinary team care conference indicated that the conference was helpful in understanding their relative's needs and the facility's care plans to meet those needs. Of CP respondents, 96.8 % indicated that they had appropriate input into the care plan for their relative; this is compared to 86.7% of comparison facility respondents.

Respondents were asked whether they had had any concerns over any aspect of the residents' care in the past year. Of CP participants 22.6% indicated that they had concerns in the past year about aspects of the residents care, however, all indicated that they were comfortable expressing their concerns to CP staff. This can be compared to the comparison facility respondents, 53.3 %

of whom indicated having concerns regarding care to their loved one. Twenty-five percent of the comparison facility respondents indicated they would not be comfortable approaching staff of the facility to address issues of concern.

When asked to comment on the residents' rooms, the majority of CP respondents took the opportunity to note that they were completely satisfied with the room. It was noted by most that the rooms were spacious, clean, tidy, and bright and that the furniture was excellent and very comfortable. A few respondents indicated that the rooms were too dark and that they had to purchase extra lighting (lamps). Respondents were particularly pleased that the resident had their own washroom facilities and that they were allowed to decorate the room with their own belongings, thereby making the environment reminiscent of their own private dwellings in the past. It was noted that there was plenty of closet space, a sprinkler system, and adequate electrical outlets to meet the residents' needs.

Most respondents of the comparison facility were satisfied with resident rooms, however some did note that the cleanliness and tidiness could be improved. It was also noted by these respondents that they particularly liked that residents were permitted to decorate their room as they wished. That being said, it was noted by two respondents that it is unfortunate that residents in protective care are unable to have pictures or personal belongings to decorate the rooms. However, these respondents indicated they understood this was for the residents' well being and that such precautions are necessary for protective care units.

Respondents of CP noted that the residents' privacy was extremely well respected at all times and that there were no concerns with this aspect of care. It was noted that family could visit privately in the resident's room or in a private family room that is nicely decorated with comfortable furnishings. Some respondents noted that the resident had little privacy due to the resident's condition and need for constant supervision. Respondents noted that it is difficult to provide an individual requiring level IV care with a great deal of privacy but that the staff at CP should be commended for at least trying to provide as much privacy to such residents as possible. Likewise, participants of the comparison facility indicated that residents had an adequate level of privacy and that there were private rooms available for visiting with family members.

All respondents were extremely satisfied with the amenities provided to residents at CP. It was noted that there are phone and TV services available and that besides personal televisions in the residents' rooms, there is access to a large screen TV that is especially valuable for those with impaired eyesight. Respondents were also extremely impressed with the hairdressing services offered to residents at CP and noted that the fee for this service was not excessive. Respondents commended the staff for being so flexible and accommodating to residents in regard to hairdressing services. At the comparison facility, several respondents noted that their loved ones, given their medical condition, did not have any use for phone or TV but that the availability of a hairdresser on site was greatly appreciated. Some respondents felt that increasing the number of hairdressing hours and making the service more flexible could improve hairdressing services.

Some CP respondents felt that there was 'absolutely nothing' else needed in terms of services to improve residents' satisfaction. Suggestions that were made by other respondents for improvement or change to services included providing a place for x-rays for residents, increasing the number of volunteers providing friendly visiting services, and improving staff scheduling to

ensure that staff caring for a resident is more consistent and communication is improved.

When asked to comment on any other aspect of care or service provided by CP, most took this opportunity to comment on how satisfied they were with the facility in all aspects of care provided to its residents. Some respondents noted that they were upset that they were not informed that the nursing home subsidy their loved one is receiving to live at CP is conditional in that it is part of a pilot project. These respondents felt that had they known this was part of a pilot project they may not have decided to admit their loved one to CP as they feel the move to another facility would be devastating.

When asked whether there were changes or improvements that should be made to the services available, several respondents at the comparison facility took this opportunity to commend staff and the home in general for providing a high level of care to residents. Others made the following suggestions:

1. Be more proactive in scheduling medical appointments
2. Increase volunteer services
3. Increase number of RN supervisors

When asked to comment on any other aspects of the care provided at the comparison facility, most respondents took the opportunity to reiterate that they were satisfied with the care provided. Others made the following suggestions and comments:

1. Increase communication with family members
2. Increase staff
3. Ensure better care of personal belongings

MUNSH

There were no differences found between the two samples with respect to happiness as measured by the Memorial University of Newfoundland Scale of Happiness. This measure was not used with the PMKs of deceased residents as there was concern that it might be upsetting to ask questions like "In the past month have you ever felt on top of the world" with reference to their deceased family member. Given that the PMKs of deceased individuals did not complete this measure, it is possible that the sample size was not sufficient enough to detect a difference. Further, this measure provides respondents with the option of 'don't know' for each question and as such many PMKs availed of this option when responding to the majority of questions. This contributes to the evaluator's lack of confidence regarding the utility of the data as an indicator of resident happiness.

Findings based on Quality of Life and Satisfaction with Care

1. Because of questions about the candidness and motives of the respondents, firm conclusions cannot be drawn based on specific questions and domains.
2. While the information presented here may provide guidance as to service areas that could be improved at both facilities, policy or procedural changes should not be based on this information alone.
3. Based on the consistency at which CP was rated more favorably than the comparison facility, it is the general conclusion of the evaluators that the quality of life and satisfaction with care

at CP is equivalent to, if not slightly better than, the quality of life and satisfaction with care at the comparison facility.

VI. Quality of Care[7]

Various aspects of this evaluation have covered the concept of quality of care. The three most important are the compliance with standards, resident quality of life, and resident satisfaction with care. It is inferred from the compliance with standards review that the quality of care at CP is adequate. It was reported that CP is compliant on the majority of standards set forth in the agreement. Some areas of noncompliance that are of concern include: 1) the fact that the nursing skill mix is not at the agreed upon level, 2) a lack of involvement by Social Workers, Occupational Therapists, Physiotherapists, and Clinical Dieticians with Interdisciplinary Case Conferences, and 3) the lack of a Recreational Specialist.

When compared to the comparison facility, there are three areas that were discussed in the compliance with standards reports that are pertinent here: 1) infection rates, 2) medication errors, and 3) falls. The December 2002 report notes that between March and October 2002 there were a total of 38 medication errors reported at CP (based on a total of 85 residents). The December 2002 compliance with standards report notes that the comparison facility reported one medication error for the same period for the whole facility (128 residents). There were 27 medication errors reported for all 977 beds in SJNHB facilities for the slightly shorter seven-month period from April to October 2002.

The December 2002 report indicates concerns with infection rates at CP that were considerably higher than those at the comparison facility for the seven-month period from April to October 2002. For CP, infection rates for that period averaged 18.4%, while for the comparison facility infection rates averaged 10.5%. It should be noted that infection rated were not reported for the comparison facility for August 2002.

For the same time period (i.e., April to October 2002) CP fared better than the comparison facility with respect to the percentage of residents that experienced falls. For CP, falls averaged 25.7%, while for the comparison facility falls averaged 32.5 %.

The measures of quality of life and satisfaction with care are appropriate as indicators of quality of care. It is certain that a resident's quality of life at a nursing home is reflective of the quality of care. In fact, the QOL questionnaire is described by its developer as also being a measure of quality of care (Kane et al. 2000). While the data do not permit strong inferences regarding the comparison between facilities, it is concluded that the quality of care that residents at CP receive

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[7] Representatives of CP and SJNHB questioned the comparability of some of the variables discussed in this section (specifically with regard to: 1) meeting the recommended LPN ratio, 2) infection rates, and 3) medication errors). Justifications for the differences between the public and private facilities were provided by CP and SJNHB representatives. These explanations could not be verified without extensive inquiry, and as such are not included here. The reasons for the differences between the public and private facilities should be examined in further research.

is excellent. The satisfaction that residents/PMKs report regarding care is also indicative of the quality of the care. Responses on the measure of satisfaction were highly favorable towards the care that is being provided at CP.

Findings based on quality of care

1. Based on the aforementioned indices, and the accreditation that CP has received, it is the finding of this evaluation that the residents of the pilot project are receiving high quality care.
2. Issues associated with skill mix, infection rates, medication errors, the involvement of key professionals with Interdisciplinary Care Conferences, and the availability of a Recreational Specialist need to be addressed.

VII. Perceptions of CP as a new option for nursing home care

Participants from both the comparison facility and CP were asked for their perceptions regarding the addition of CP as a new option for nursing home care. Respondents were also asked if residents should have a choice in the long-term care facility in which they reside.

Nearly all the comparison facility respondents who were familiar with CP indicated that they felt that CP should be available to residents of the province needing long-term care, particularly because they felt that there is a great need for more beds. Some noted that they felt the care provided to residents was similar for both facilities.

All but two CP respondents felt that having CP available for nursing home clients was a good option. Respondents noted that the waitlist for clients is too long and that CP will assist in reducing the wait list numbers. Many indicated they felt that the fact CP is new, modern, and up to date was very important and that government should try to get public homes up to a similar aesthetic standard. Several respondents indicated that CP would be a good option only if certain conditions were met. Specifically it was suggested that: 1) it should not cost taxpayers extra, and 2) all the same services (including social work, occupational therapy, physiotherapy and recreation therapy) should be available to residents of CP as are available to residents of publicly funded long-term care facilities.

All respondents from both facilities felt that residents should have a choice in the long-term care facility in which they reside. The majority of the comparison facility respondents felt that there was currently such a choice available; alternatively, the majority of CP respondents stated that there was very little choice available to residents. However, CP respondents did indicate that the level of choice available was directly related to the residents' financial capabilities.

Key informants to this evaluation were also asked for feedback on this matter. For the most part, key informants were not aware of the perception of residents and their families around the addition of CP as a new option for nursing home care. Those individuals that did feel capable of commenting on the matter provided conflicting reports based on limited interactions with residents and their family members.

Findings based on resident, PMK, and key informant interviews

1. The comparison facility and CP respondents view the addition of CP as a new option in

nursing home care rather positively.

2. The majority of the comparison facility respondents feel that residents currently have some choice in the long-term care facility in which they reside, while the majority of CP respondents feel that little choice is available

VIII. Impact of subsidy provision on willingness to privately pay for accommodations at CP

All key informants were asked for their viewpoints on the impact of the nursing home subsidy provision on individuals/families willingness to privately pay for accommodations at CP. Overall, respondents felt incapable of addressing this query because of a lack of discussion with residents and family members regarding the issue. However, a small number of individuals that had discussed the matter with residents/families, or had had relevant experiences, offered some insights. Management at CP indicated that the nursing home subsidy had not had an impact because the facility still gets new residents coming in, and in fact CP has more privately paying people now than they had a year ago. A representative of SJNHB indicated that individuals that pay privately in the public system are influenced by the fact that the majority of others around them are not paying for care. It was noted that often these individuals try to hide their assets so that they will not have to pay. One representative of HCSSJR offered the opinion that the project may be causing individuals to enter CP with the belief that if their funds run out then government will pay for them to stay there. Alternatively, it was noted that this project might demonstrate that individuals are willing to pay for their care until they run out of funds.

Finding

1. There is not enough information available to generate findings for this section

IX. Impacts and effectiveness of the agreement for involved parties

This section of the report will address various indicators of the ongoing impact and effectiveness of the pilot project for all parties involved. Specifics to be addressed include: 1) professional/personal impacts on the key stakeholders, 2) comprehension of the roles of CP and SJNHB, and 3) benefits and challenges for key stakeholders.

Professional/personal impact on key informants

A key aspect of any program is the impact that it has on the individuals that are involved with its administration. Overall, it appears that the CP pilot project has had the most impact on representatives of CP and SJNHB. With respect to CP, management noted that the project has been a learning experience, and it has been rewarding to know that the care that is being provided at CP is as good as in the public nursing home system. Respondents indicated a positive personal impact in that the residents that had depleted their funds were able to stay at CP. A negative personal impact that was noted surrounded worry regarding the future of the project and the residents that are availing of the nursing home subsidies. With respect to

SJNHB, respondents indicated that there was no personal impact; however there were a number of areas of professional impact. These included: 1) role expansion as a result of dealing with the private-for-profit system and heading in a new direction, 2) the project has been more time consuming than originally anticipated, and 3) there is an adjustment of strategic direction – from anticipating involvement with the private sector in the future, to dealing with it in the present. The majority of respondents from both DOHCS and HCSSJR indicated that the project had not had an impact on them either personally or professionally.

Understanding of roles of CP and SJNHB

For a project to operate effectively, it is essential that the key stakeholders have a good understanding of the roles and responsibilities of each participating organization. It is evident that all parties involved with the CP pilot project have a general understanding of the basic roles of CP and SJNHB. It was thought that CP is to provide care that meets the standards of government and SJNHB, to the 30 residents in the pilot project. All key informant groups felt that SJNHB had two major roles – monitoring the compliance with standards, and handling the finances. In terms of finances, it was indicated that SJNHB is responsible for processing the nursing home subsidy payments to CP on behalf of the residents, and to conduct financial assessments of the subsidized clients. It should be noted that representatives of SJNHB stated that the role of, and degree of monitoring required by, SJNHB hasn't been clear. That respondents had a basic as opposed to an in-depth understanding of the roles of CP and SJNHB for the pilot project might signify one of two things: 1) the key stakeholders do not fully understand the roles of each organization, or 2) the roles of each organization have not been clearly developed and conveyed.

Benefits/challenges for key stakeholders

The current evaluation has assessed the impacts of the pilot project on each of the involved parties through personal interviews with key informants from each organization. Presented below is a discussion of the benefits and challenges for each organization that was involved with the CP pilot project.

Chancellor Park staff and management

It is felt by management at CP that entering into the pilot project has validated the long-term care service that is being offered there. Further, staff now feel like they are a part of the long-term care system. It was indicated that knowing that the residents whose funds had expired, and whom staff had cared for, would not have to leave CP (at least for the duration of the pilot) was a relief for the staff. Additionally, it was thought that the extra thirty residents at CP might have prevented layoffs that would have been necessary had these residents moved to another facility.

It was noted by CP management that a challenge has been the uncertainty regarding the future of the project and the residents. Another difficulty that was stated was the unfair way that the media has portrayed CP. It was indicated that this might affect the willingness of residents to come to CP. However, it is uncertain if the media attention is associated with the pilot project or other issues.

St. John's Nursing Home Board

Representatives of SJNHB indicated that the primary benefit for that organization has been the ability to examine a new method of providing care; e.g., different staffing skill mixes, policies,

and programs. It was stated that it has been an opportunity to test the private-for-profit provision of high-level long-term care from a funding and quality perspective. It was described as a chance to look at providing care with a different skill mix, as is happening in the other provinces. Respondents noted that the project provides additional beds in the form of a facility that is very new and attractive as compared to the older public facilities.

SJNHB representatives noted many challenges and difficulties have been encountered as a result of participating in the pilot project and stated that it has been very time consuming. The major themes that emerged surrounded the level of monitoring required and dealing with the perceptions of the public nursing homes. It was stated that the role of, and degree of monitoring required by, SJNHB hasn't been clear. It was noted that monitoring has been challenging because there is no formal monitoring mechanism for long-term care in this province. Similarly, the project has been difficult to administer without provincial policies and standards for long-term care. With respect to dealing with the public homes, SJNHB representatives alluded to challenges in dealing with facilities under the SJNHB that perceive the private-for-profit operator as a competitor. Further, it was indicated that there might be a perception of a conflict of interest in that SJNHB is a public organization and is doing the monitoring of the pilot project. SJNHB representatives also noted difficulties in dealing with the perception that beds are being closed in the public homes and contracted out to the private-for-profit facility. Some apprehension regarding public-private partnerships was stated in that the public might equate quality of care with the look of the facility and individuals may be more likely to choose to live at CP as compared to any of the other facilities. This might decrease the competitive abilities of the public facilities.

Health and Community Services St. John's Region

HCSSJR representatives stated one benefit to that organization – another choice for the placement of clients. It was felt by respondents that the participation of CP in the Single Entry System has been a very smooth process, with the acceptance of clients in a very short time frame. It was noted that this has not always been the case with SJNHB homes.

Challenges that were indicated by HCSSJR representatives were related to the placement of clients. It was stated that it has been challenging trying to balance accommodating individuals that have exhausted their funds at CP and community emergencies. Respondents noted frustrations with the current requirement of offering CP to clients as a preference option in the Single Entry System. It was noted that many clients of the Single Entry System have requested CP as a preference for nursing home care. The system dictates that clients be told they can be added to the waitlist for CP, but key informants felt providing this option was misleading to clients. They felt that realistically there is little chance a client will be placed there if they are not from the Community Emergency Group, as space available for individuals receiving nursing home subsidies at CP is limited to 30 beds. One specific challenge that was voiced involved the placement of clients with complex needs (e.g., Level IV ventilated) and the fact that DOHCS would not provide extra funding to accommodate such individuals at CP.

Department of Health and Community Services

DOHCS representatives indicated that the pilot project is an opportunity to learn more about public-private partnerships and the public vs. private-for-profit methods of providing care. It was also noted that it is beneficial to provide another option for client placement and possibly to make nursing home care more cost-efficient. For the most part, DOHCS representatives did not

feel that the Department had encountered any difficulties or challenges as a result of its involvement with the pilot project.

Findings regarding impacts on key stakeholders

1. The pilot project has had a large impact on management at CP and SJNHB; however, there appears to have been minimal impact on representatives of HCSSJR and DOHCS.
2. The involved boards have a basic overall understanding of the roles of SJNHB and CP. It is suggested that the roles be reviewed periodically and refinements made when misunderstandings occur.
3. The pilot project has allowed CP to retain some residents whose funds had expired, gain new residents through the Single Entry System, and to be validated within the long-term care system.
4. SJNHB has been able to examine a new method of providing care that might be more efficient than the public system. However, there have been difficulties encountered in terms of the level of monitoring required and the perception of the public system towards public-private partnerships.
5. The project has generally been beneficial for HCSSJR in terms of a new option for placement that operates more smoothly than the public system. However, there have been some problems encountered with managing the Single Entry System in association with the pilot project.
6. The pilot project has provided DOHCS with the opportunity to learn more about public-private partnerships and the public vs. private-for-profit methods of providing care.

X. Cost-effectiveness

In order for the consultant to determine the cost-effectiveness of the CP pilot project for this province, it was appropriate to undertake a comparison and analysis of the costs of delivering level III nursing care by both the public system as represented by SJNHB and CP. The objective was to determine if CP's costs are higher, lower or equal to SJNHB while delivering an acceptable quality of care to the residents funded under the pilot project. This analysis requires that the results of the effectiveness of the pilot project have to be considered to provide an overall determination of its cost-effectiveness. For example, it is possible that a particular project may rank less in cost than its comparator but be assessed as unsatisfactory in the results it achieved; as such, it would not be considered to be cost-effective.

As a second measure of cost-effectiveness, the results of the comparison of the costs of the pilot project were compared to a proxy cost of delivering nursing home care in the four comparator provinces selected for this evaluation. The proxy cost is defined as the amount of fees charged in these four provinces. The consultant did not collect data on nursing home operating costs in the four provinces but relied on information on the fees charged as an approximate determinant of their costs. Unlike in the public system in Newfoundland and Labrador where the fees are a portion of the cost to operate the nursing homes, the fees presented herein are the fees required to fund the cost of operating the nursing home facilities in the respective provinces. The results of this analysis are intended to place the pilot project in the range of costs incurred in the other

provinces.

Data was not collected from the four provinces on the overall quality of their nursing home services. The key indicator of quality used for this component of the evaluation was the level of hours of nursing care provided. It is recognized that this is not the definitive measure but is one that is often referenced in the studies and reports on measuring quality of nursing home care. Data on hours of nursing care provided in each of the provinces was assembled and compared to similar data provided by CP.

The costing data was collected from finance officials with SJNHB and CP. In order to get as accurate a comparison as possible, SJNHB selected one of their nursing homes with a comparable group of Level III category residents as the comparison facility. This facility was selected from the several facilities managed by SJNHB to maximize comparable features in construction, size, and amenities to CP. The data was assembled by the consultant and shared for comment with the finance and administration officials of both facilities.

It should be noted that the costing data presented in this evaluation is deemed to be representative of the costs of operating each of the two facilities but is not intended to represent the actual cost for both facilities. The reader should be cautious in interpreting the data as the basis for calculating resident fees or provincial operating subsidies.

The following table represents a summary of this data:

Table 1 Comparison of Nursing Home Operating Costs: Comparison Facility & Chancellor Park

Cost and Revenue Items	Comparison Facility		Chancellor Park (CP)	
	Col. I	Col. II	Col. III	Col. IV
	Based on 18 months costing	Based on 10 months costing	Based on 10 months Costing	Based on costs at 92 % occupancy
1. Direct Resident Care Costs (includes nursing, dietary, allied health & other (per diem)	$ 134	$ 135	$ 79	$ 83
(per month)	*4080*	*4095*	*2409*	*2532*
2. Indirect Resident Care Costs (includes admin, utilities, laundry, housekeeping & maintenance) (per diem)	77	81	71	65
(per month)	*2347*	*2471*	*2167*	*1986*
3. Sub-total before extraordinary items (per diem)	211	216	150	149
(per month)	*6426*	*6565*	*4576*	*4518*
4. **Total**				
(per diem)	**211**	**216**	**169**	**167**
(per month)	***6426***	***6565***	***5139***	***5073***
Less: Related Revenues				
5. Resident Contribution (per diem)	(36.99)	(35.23)	(40.32)	(40.32)
6. Foundation funds (per diem)	(0.25)	(0.25)	(0.00)	(0.00)
7. Other recoveries (per diem)	(10.65)	(10.84)	(0.00)	(0.00)
8. ***Net Operating Cost Deficiency*** **(per diem)**	**163**	**170**	**129**	**126**
(per month)	***4970***	***5157***	***3912***	***3847***

Table Notes:

1.Column I data was supplied by SJNHB as originally requested by the consultant and was adjusted periodically as new data was supplied by the CFO.

2.Column II data was prepared by the consultant based on data extracted from the Column I data supplied by SJNHB to allow the consultant to undertake a better comparison to Chancellor Park's data that was supplied for a 10-month period.

3.Columns III and IV data were supplied by Chancellor Park and were adjusted periodically as the Director of Budgeting supplied new data.

4.Financial statements were not provided to the consultant. The consultant believes the costing data to be 'representative' of each home's operating costs that can be used for comparative purposes for this evaluation.

5.The data is intended for cost comparisons only as part of an evaluation study. The data is not designed or presented to determine resident fee structures or provincial subsidy arrangements for these homes.

Analysis of the cost of the pilot project

Based on the data provided by SJNHB and CP, the monthly cost of operating a nursing home bed for a Level III category resident in one of their facilities is $6,565 for SJNHB and $5,139 for CP. The differential in costs is $1,426/month for each resident (per line 4 in Table 1). Currently, SJNHB charges $2,800 for its beds (referred to as the private pay rate by SJNHB) though its costs are significantly higher. CP residents are also expected to pay the current $2,800 fee charged to residents in the public system. In both cases, where the resident is unable to pay, a provincial subsidy is provided to the operator. In the case of CP, the maximum amount it receives under the pilot project is $4800 per resident per month whereas SJNHB receives the higher amount ($6565). CP normally charges $5,000 for a semi-private room and $5,500 for a private room for Level III category residents.

The costing data can be furthered analyzed and compared for direct nursing care costs, indirect resident care costs and other costs.

Direct resident care cost items

The largest single cost item is direct resident care. It represents 46 per cent of the comparison facility operating costs and 36 per cent of CP operating costs. Furthermore, the difference in cost of $38.03 per resident day for this item represents 81 per cent of the cost differential between the two nursing home operators.

The factors that make up the cost differential for nursing care are as follows:

1. Though the comparison facility and CP use the same levels of RN nursing care, CP uses a higher ratio of PCAs as well as permits its LPNs to practice within their expanded scope of practice. This, along with lower remuneration costs for CP's PCAs, results in a lower cost for CP equal to $7.50/hr for each hour of care provided.
2. On average, the comparison facility's compensation costs for its RNs are higher by $2.94/hr. Data on compensation costs exclude any severance pay costs. Each operator has a different employee benefit arrangement and this cost is not applicable to the pilot project.
3. The comparison facility incurs an additional cost for nursing replacements and other requirements that equates to 0.75 hour of nursing care per resident day.

Other direct resident care costs cover dietary, medication, allied health social work, pastoral care, recreation, transportation and medical supply services. CP costs are lower by $17.40 per resident day owing primarily to two factors:

1. The most significant factor is that CP compensation costs for dietary services are lower than the comparison facility.
2. CP does not have Social Workers on staff, and allied health services are contracted-out.

Indirect Resident Care Cost Items

Indirect resident care costs contribute to 38 per cent of the comparison facility's operating costs and 42 per cent of CP costs. The difference in these costs is $9.98 per resident day in favor of CP.

The main factors that make up the differential in costs are as follows:

1. The comparison facility incurs administration costs that amount to $31.38 per resident day while CP administration costs amount to $18.57 per resident day. Of the amount that the comparison facility incurs, $18.41 per resident day is for its share of the costs for the regional administration function; that is not a cost that CP has to incur. As a manager of several nursing homes in St. John's, SJNHB has to provide for several system-wide functions that are not warranted for a single facility. The consultant did not assess the appropriateness of the level of expenditure on the various elements that constitute these costs for either facility.
2. There is a significant differential in compensation costs for housekeeping and laundry services in favor of CP.
3. CP has to pay both water and property taxes whereas the comparison pays only water taxes.
4. CP has a higher level of debt financing costs (interest payments only) as it is a newer facility and privately financed.

Other Cost Items

There are two cost items that CP incurs that the comparison facility does not. These items are a provision for profit and corporate taxes on these profits. As a private-for-profit operator, CP expects to earn a profit on its operations; at the same time, it has to pay a tax on these profits. These cost items are reflected in its operating cost structure and contribute to the basis of its resident fee structure.

The two items are described below:

1. CP has determined that its operating costs should include a provision for a profit equal to 10 per cent of its direct and indirect resident care operating costs. This would amount to $15.04 per resident day. CP's auditors have advised CP that, though there is no generally accepted method of determining an annualized rate of return on invested capital, real property investors seek a return on equity in the range of 8-12 percent. At the same time, CP is also operating a nursing home business and expects a reasonable return on this portion of its business activity; thus the 10 per cent proxy cost for profit used by CP. If the return on equity calculation were employed instead in the analysis, the cost per resident day would be reduced to $11.21 (a difference of $3.83 per resident day or $116/month).
2. As a private-for-profit operator, CP allocates a cost for corporate income taxes based on a tax rate of 23 per cent of its operating profit, or $3.46 per resident day. (This amount would be reduced by $0.88 per resident day or $27/month if the calculation of profit, as discussed above, is amended.)

The foregoing analysis is based on the cost to operate the 30 beds funded under the CP pilot project in comparison to an equivalent number of beds at one of the SJNHB facilities. The conclusion to be reached is that CP costs are less by at least $1,426/month for each resident, or $513,360 less in total for the pilot project, on an annual basis. The SJNHB has to cover some cost for providing social work services to CP and for administering the agreement with CP.

One other calculation that the consultant completed was to determine if the costs for CP and the differential in costs with the comparison facility would be materially different if CP was operating at full capacity. In this situation, CP would have the ability to allocate its costs over a larger revenue base; it would also require CP to incur additional costs. Column IV in Table 1 provides the results of this costing exercise. Though CP has 188 beds, it currently operates at 48.3 per cent capacity; its target occupancy rate is 92 per cent. In comparison, SJNHB operates

at 97.4 per cent occupancy (similar to the normalized level for public funding purposes in Ontario). For this exercise, CP costs were recalculated based on its target occupancy rate of 92 per cent.

The results of this exercise show that CP's operating costs per resident would decline from $5,139/month to $5,073/month, a difference of $66/month. This reduction in CP costs would result in the differential with the comparison facility increasing to $1,492/month for each resident.

Resident and other contributions towards operating costs

Both the residents of the comparison facility and the CP pilot project contribute to a portion of the cost of their care. For the comparison facility residents, the average contribution has been calculated at $35.23/day or $1,072/month versus the private pay rate of $2,800/month charged by public nursing homes. CP pilot project residents contribute slightly higher at $40.32/day or $1226/month.

In addition, the comparison facility benefits from government grants for equipment, foundation funds and other cost-recoveries, none of which have been available to CP.

The result is that neither home collects sufficient fees to meet their operating costs and they both rely on government subsidies to make-up the difference. The operating cost deficiency calculated for the comparison facility and CP, per line 8 of Table 1, is defined as the difference between the operating cost and the resident fees and other financial contributions. It shows that CP's operating cost deficiency is $3,912/month compared to a comparison facility deficiency of $5,157/month, a difference of $1,245/month, or $1,280 if government's capital grants are excluded.

Comparability of nursing home operating costs with other provinces

The consultant considered the costs of operating nursing homes in the four provinces selected for this evaluation. Public officials in the four provinces were contacted and asked to provide data on the cost of operating nursing homes and the fees charged to residents for their care. This data will be compared to the data collected for the CP pilot project to determine the comparative cost of each system.

1. New Brunswick (NB)

New Brunswick officials did not provide data on actual operating costs. They indicated that the cost of nursing home care could be determined based on the fees charged (i.e., the fees generally equate to the cost of operating the nursing homes). These fees range from $3,800/month to $5,000/month. Nursing homes are required to provide a minimum of 2.5 hours of nursing care daily. In comparison, CP costs are determined to be $5,139/month while providing 3.2 hours of nursing care. On the assumption that all other cost elements are equal, and CP reduced its hours of care to the NB minimum of 2.5 hours, then CP's operating costs could be less by $419/month, placing it within the higher end of the NB range of operating fees.

2. Nova Scotia (NS)

Nova Scotia officials advised that the daily rate is the indicator they use to provide data on overall operating costs for nursing homes, as the rate is set after examination of the valid costs of operating these homes. The daily rate ranges from $110/day to $199/day and reflects the standard of care provided along with each nursing home's other operating and capital costs. On a

monthly basis these fees amount to $3,346/month to a high of $6,053/month. In comparison, CP costs are determined to be $5,139/month. The level of nursing hours of care is equal to that provided by CP. On the assumption that all other cost elements are equal, CP's operating costs place it above the mid-range of NS per diem rates.

3. Ontario

The consultant did not collect data on Ontario nursing home operating costs. Similar to the other provinces, data on the regulated per diem fees were used as a proxy cost of operating nursing homes for comparative purposes for this evaluation. Nursing homes are allowed to charge a specific but different rate to compensate them for their operating costs. When combined, the rates provide for a range of fees that on average equal to $3,368 to $4,240 month. In the event that a nursing home has a higher case mix of residents then the higher nursing cost associated with this higher level of care is compensated through a higher approved rate for nursing and personal care. This increases the range of fees that these homes can charge.

The largest difference among the cost elements that would have a direct impact on operating costs relates to the nominal hours and mix of hours of nursing care. Ontario does not have a prescribed standard but some information suggests that the actual level of nursing care is in the range of 2.5-2.8 hours of care; whereas CP delivers 3.2 hours of nursing care. On the assumption that all other cost elements are equal (a broad assumption given the expected price differentials for land, construction and labour between Ontario and St. John's), and CP reduced its hours of care to 2.5 hours, then CP's operating costs could be less by $419/month. This would still place CP outside the upper end of the Ontario range of approved fees.

4. Saskatchewan

Saskatchewan officials provided data on operating costs similar to the other provinces; namely, they made reference to approved fee structures that are representative of the cost of operating facilities in that province. At best, they could only provide an average cost for nursing home beds that was in the range of $ 4,250/month to $4,600/month. Levels of nursing care are approved at 2.0 hours of care augmented by some additional hours of care for specific purposes. On the assumption that all other cost elements are equal and CP reduced its hours of care to 2.0 hours, then CP's operating costs could be less by $718/month. This would place CP within the mid-range of Saskatchewan's operating costs.

Findings on cost-effectiveness

The following findings in relation to the cost-effectiveness of the pilot project are provided:

1. The cost of the pilot project delivered by CP has been determined to be less expensive than the cost of operating a similar number of beds with the same category of residents (Level III) by the comparison facility; this differential is estimated at $1,426 month.
2. This cost differential increases as CP increases its occupancy level as it has the opportunity to allocate its fixed costs over a larger resident (i.e., revenue) base.
3. There are many factors to be considered in the costing data and in comparing the difference in the overall costs; some of the more relevant factors are as follows:
   a. Each facility's single largest cost component is for direct resident care that includes RNs, LPNs and PCAs.
   b. Each facility provides the same level of registered nursing hours of care for each Level III

category resident and has the same RN/non-RN nursing mix though CP uses a higher proportion of PCAs than SJNHB.

c. CP will need to increase its availability of physiotherapy, occupational therapy, social work services and nutritional assessments, which will add additional costs to its operations (and reduce the current cost differential by $2.00-3.00/day); these costs are reflected in its target occupancy costing data.

d. The comparison facility's nursing care compensation costs include benefits and callback costs that greatly exceed CP's; when combined these factors represent 88% of the cost differential between the two facilities; similar trends are noted for dietary, housekeeping and laundry costs.

e. Owing to the fact that SJNHB manages six facilities in St. John's and Mount Pearl, SJNHB facilities have to bear a proportionate share of the regional administration costs; CP does not incur similar costs.

f. The quality of the physical condition of the facilities has not been taken into consideration in this evaluation. CP, a new facility, appears to provide a higher level of comfort amenities and is in overall better condition in relation to the comparison facility and this contributes, in part, to its debt financing costs that are considerably higher than the comparison facility; the corollary being that the comparison facility's costs would increase as capital and equipment improvements are made to equal CP's standards.

g. CP, as a privately owned facility, has to make provision in its cost structure for a rate of return on investment (i.e., profit) and the payment of corporate income tax and municipal property tax; these costs do not have to be incurred by the comparison facility as a non-profit facility.

4. The CP pilot project effectiveness is demonstrated in the findings presented from the review of (i) the compliance with standards as set out in the agreement, (ii) the review of the staff complement and hours of care, (iii) the assessment of the quality of life and resident satisfaction, and (iv) the overall assessment of quality of care. Certain deficiencies in the pilot project were observed but the overall effectiveness of the pilot project has been demonstrated.

5. Overall, based on the data collected and analyzed for this evaluation, the CP pilot project is determined to be cost-effective in relation to the SJNHB.

6. In relation to three other provinces (NB, NS and Saskatchewan) - both in terms of the cost comparisons and the quality of care as measured by the hours of nursing care provided - the CP pilot project is assessed to be cost-effective, albeit CP's comparative costs are at the higher end of the range of these other provinces' costs. Only one province, Ontario, has lower comparative costs and the pilot project would not be cost-effective in relation to that province.

7. Based on the data collected from other provinces and the current cost-effectiveness of the pilot project, there are no identified reasons as to why any future public-private partnership arrangements for long-term nursing care in this province should not also be cost-effective. It is recognized that further analysis will have to be completed by government and its stakeholders taking into account such significant factors as the cost of land and building construction, and employee compensation costs based on required skills and remuneration rates before such an arrangement is contemplated.

8. Further analysis is required to ensure that current cost-effectiveness is sustainable in the long term.

XI. Financial accountability to and at all levels

The detailed contract and standards for the pilot project outline a number of financial accountability mechanisms. These are summarized/reiterated below:

1. Nursing home subsidies for individuals participating in the pilot project are paid through SJNHB
2. The nursing home subsidy amount is $4800/month and will be reduced if an individual has the ability to pay a personal contribution as determined by SJNHB, and/or if an individual is currently in receipt of home support funding.
3. Individuals who require Level III and IV care and are in receipt of home support funding from HCSSJR will continue to receive this funding toward the maximum amount of the nursing home subsidy until their death or discharge from CP.
4. The SJNHB shall account to DOHCS in relation to funds allocated to CP as DOHCS may require.
5. SJNHB will require CP to account in accordance with this Agreement for funds provided by way of a nursing home subsidy from the Board to the 30 individuals at CP.
6. Residents are financially assessed by SJNHB and approved for a nursing home subsidy
7. SJNHB will monitor such financial records of the 30 individuals receiving a nursing home subsidy at CP, as the SJNHB in its sole and absolute discretion deems necessary to ensure compliance with the terms of the letter of agreement.
8. SJNHB will, upon reasonable notice to CP, review the financial records of the 30 individuals receiving a nursing home subsidy and report to the DOHCS on the same.

Overall, this evaluation has not uncovered any major problems regarding financial accountability. Key informants felt that CP has been very cooperative in regards to supplying financial information and that all interactions have gone smoothly.

The Phase I evaluation stated that the vast majority of the subsidized residents at CP were in receipt of a home support subsidy prior to transferring to the nursing home subsidy. While in March 2002 a total of 20 of the profiled residents had been in receipt of home support subsidies at Chancellor Park prior to receiving nursing home subsidies, only 17 of the residents profiled in December had received such home support subsidies while residing at Chancellor Park. This indicates that since the phase one evaluation there has been a decrease in the number of residents that were in receipt of home support subsidies prior to receiving nursing home subsidies.

One issue of accountability that has direct implications for residents is the management of trust accounts. Each month a Clothing and Personal Care Allowance of $125 is deposited to each resident trust account. To examine the trust accounts of residents, the resident/PMK participants of the evaluation were asked about items and services that they were required to pay for in addition to the cost of living at the facility. Presented in Table 2 are the items that residents/PMKs at both facilities believed they pay for, as well as the items that the facilities indicated that residents have to pay for.

Table 2: Comparison of resident/PMK opinions[8] and facility reporting regarding the use of resident trust accounts.

Chancellor Park		Comparison Facility	
Resident/PMK opinions	Items reported by Facility	Resident/PMK opinions	Items reported by Facility
• Cable TV • Telephone service • Hairdressing • Clothes • Newspapers, magazines • Dry cleaning • Personal care items (e.g., cream, toiletries) • Disposable undergarments • Percentage of drug costs	• Cable TV in their own room • Telephone service in their own room • Hairdressing services • Canteen services • Dental care • Prescription eyeglasses • Clothes • Make-up • Newspaper delivered specific to the resident • Postage for letters/parcels • Drug costs: drug fees dependent upon drug card	• Personal care items • Hairdressing • Eye glasses • Snacks	• Hairdressing • Percentage of drug costs (dependent on resident's drug card) • Toiletries and personal care items • Incidentals (i.e., clothing, make up) • Items from facility gift shop • Transportation needs (i.e., Wheel Way bus sevices)

This table indicates that there is some degree of correlation between what residents and PMKs feel they are paying for and what the facility has reported. One area of contention is the supply of disposable undergarments. Five PMKs thought that they have to pay for disposable undergarments, while CP indicated that this item was covered by the nursing home subsidy. It is possible that residents of CP had to pay for disposable undergarments while receiving a home support subsidy and were unaware that this expense was being covered by the nursing home subsidy.

At CP, some participants noted that they felt disposable undergarments and hairdressing should have been covered by the cost of living at the facility. It was also suggested that

[8] It should be noted that only items that were mentioned by two or more participants are reported

residents/families receive statements of spending for the trust account funds more often. The majority of respondents noted that they had no objections to paying for the extra services and most noted that the rates were reasonable. Several respondents noted that they like to buy these things for their loved one because it makes them feel good and they can give them to the resident as a gift when they visit. However, when respondents were asked specifically if they felt that these items should be included in the cost of accommodations, several indicated feeling that the dispensing and/or prescription drug fees should be included in the cost of living at CP. Many of the comparison facility respondents felt that the costs of such items should be included in the fees for living at the facility while others felt that the extra cost was appropriate and therefore had no problem paying for these items and services.

The financial services section of the compliance with standards report indicates that no residents have a signed copy of the residents trust agreement in their file. Also, it was stated that the $125 is credited to the resident trust account once money is received from the government funding side of the program and not when the resident revenue is recognized or the resident pays their portion to the board.

It was noted in the compliance with standards section of this report that policies and guidelines are in place to ensure that residents receive required medical services and aides including glasses, dentures and hearing aides, accompaniment to medical appointments, and specialized transportation. Further, residents' financial capabilities and insurance programs are assessed in billing of such services. If a resident is unable to pay for necessary services, CP always incurs costs.

Findings based on financial accountability

1. Overall very few problems regarding financial accountability.

XII. Evaluation implementation plan

Sound evaluation research can provide feedback on how well programs are operating, their impact on clients and key stakeholders, and identify need for change to a program. The stakeholders and decision makers of the public-private partnership agreement for long-term care should be commended for their commitment to monitoring and evaluation from the pilot project's initiation. Early identification of the need for evaluation allows the evaluation process to run much more smoothly, especially when evaluation consultants are provided with a competent and reliable team of key stakeholders to confer with throughout the course of the evaluation. Such a commitment to evaluation ensures the usefulness of the evaluation findings in addressing the needs of key stakeholders and improving performance.

The terms of reference have identified a number of key aspects for the evaluation of the CP pilot project that are transferable to similar arrangements. While the following evaluation plan makes reference to CP, it is recommended that such evaluation activities occur at all nursing homes. This will provide some assurance as to differences between public and private nursing homes in terms the factors discussed throughout this report. Specifically, the following components should be assessed:

Compliance with standards

Compliance with standards is currently being monitored by the SJNHB. It is suggested that this continue, however, a definitive process and accountability mechanism for such monitoring needs to be implemented.

Quality of Care

Information on quality of care for the present evaluation was collected via a number of sources including the compliance with standards monitoring reports, interviews with residents and their family members and key informant interviews. Future assessment of the quality of care should be conducted using the same methods.

Residents' quality of life and satisfaction

Data concerning residents' quality of life and satisfaction with services should be collected using standardized tools whenever possible. It is suggested that the satisfaction survey used in the present report continue to be used by CP for the purpose of self- assessment. Although the scale is somewhat lengthy, it can be completed quickly by residents or their family members. It is expected that despite the length of the questionnaire residents and their families will be agreeable to completing surveys if they are presented as tool designed to assist the facility in improving services to the residents.

Ongoing impacts and effectiveness of the agreement for involved parties

Data on the ongoing impacts and effectiveness of the agreement for involved parties was collected for the present evaluation by way of key informant interviews, and document review. A similar review of such impacts should be included in future evaluations and include administrative impacts as well as issues related to such aspects as human resources, collective bargaining agreements, legislation, and policy.

Client profile and changes

Information used in developing client profiles was obtained from resident files at CP. The information received by the consultants was thorough and complete and it is therefore recommended that such information continue to be collected on residents. It is suggested that a database that allows the tracking of resident profile information be implemented at CP, if not for all residents, at least for those who are receiving nursing home subsidies. Such a database would allow quick and easy analysis of profile data and changes in profile over the course of the partnership.

Staff complement

CP collects data regarding staff complement on a regular basis and assessments are made by compliance to standards monitoring. It is recommended that this process continue.

Hours of care

CP collects data regarding hours of care on a regular basis and assessments are made by compliance to standards monitoring. It is recommended that this process continue.

Cost-effectiveness

For the purpose of the present evaluation cost-effectiveness was assessed by way of key informant interview and document review. The cost-effectiveness of the project was assessed in comparison to facilities under the direction of the SJNHB and in comparison to other provinces

in Canada. It is recommended that this process continue to be used for the purpose of future evaluations. However, future estimates should be based on audited statements.

Impact of subsidy on individuals/family's willingness to privately pay for accommodations at CP

There has been some discussion on how to best ascertain this impact of the public-private partnership, however, no absolute method has been identified. An analysis of client trends before and after the inception of the partnership agreement may provide some insight. Further, during future evaluations it may be beneficial to pose this question to residents of CP not receiving nursing home subsidies.

Financial accountability

For the purpose of the present evaluation financial accountability was assessed via key informant interviews, resident interviews and document review. It is suggested that the same process be employed for future evaluations.

Perception of residents and their families in other facilities around the addition of CP as a new option in the Single Entry System

For the purpose of the present evaluation this question was addressed to family members and residents interviewed as part of the comparison group (i.e., those participants representing the home under the direction of the SJNHB). Future evaluations will not likely be of a comparative nature and therefore this data needs to be collected using an alternative data source. Consideration should be given to the feasibility of collecting this information using the following methods:

- Adding this question to others posed by HCSSJR during intake assessments
- Posing this question to residents of CP not receiving nursing home subsidies
- Asking for such information from a random sample of clients of the Single Entry System

Included in Appendix A is a table that includes suggestions for how these aspects of the agreement should be monitored.

XIII. Conclusions and Recommendations

Summary of Suggestions Provided by Key Informants

To assist the evaluators in developing recommendations, key informants were asked for suggestions for the future of the pilot project and for the development of similar partnerships in the province. These informants are considered to be a valuable resource based on their experiences in the field of long-term care and with the pilot project. As such their suggestions are considered to be very useful for long-term planning. However, it should be stressed that the suggestions made by key informants are opinions and should not be taken as facts. Suggestions that were provided varied considerably in terms of their specificity and ease of implementation.

Specific to the pilot project

It was felt that the decision to continue the partnership needs to be based on evidence (i.e., quality care that is cost-effective) and not on media, public, or political pressure. Further, it was

noted that before the decision as to the continuance of the partnership is made public, the families need to be briefed by professionals to prepare them for dealing with whatever direction the partnership takes. It was felt that the residents and families are under a great deal of stress because they felt that they were not informed that the placement at CP was a pilot project. It was stressed by one group that if the partnership is discontinued, the 30 residents that are currently in the pilot should remain at CP. It was also stated that the evaluation report should be made available to people working in both systems (i.e., public and private-for-profit). Further, after the evaluation is completed, staff and management from each of the involved organizations should meet to discuss future directions.

Other suggestions that were made concerned the organization and management of the project. It was suggested that there needs to be: 1) better communication between the partners, 2) more integration in the system, and 3) a more positive attitude towards the partnership. It was also stated that the need for social work and physiotherapy services should be assessed by Social Workers and Physiotherapists – not by nurses or others.

Implications for the overall provision of nursing home care in Newfoundland and Labrador

The majority of informant groups felt that the information gathered from the pilot project and the lessons learned would be beneficial to the overall provision of nursing home care in NL. Overall, it appears that the involved parties have learned that public-private partnerships can provide a means to provide high quality care in an efficient manner (e.g., skill mix). However, all raised concerns regarding the challenges encompassed in a transition to public-private partnerships. The major themes that emerged surrounded the cost of care, standards for care, and public perceptions.

In terms of the cost of long-term care, respondents felt that public-private partnerships would be beneficial for long-term care in this province in that the private-for-profit sector could build and operate facilities with private monies that government cannot afford. However, all groups indicated that there are a number of areas that require change. It was suggested that the current arrangement of subsidizing a bed within a particular home is demeaning and that it should be the individual that requires nursing home care that is subsidized. It was also stated that individuals that require nursing home care should be required to pay for their care according to their financial means. However, it was also felt that private paying residents that enter private-for-profit facilities need to be informed that when their funds run out they can no longer stay at the facility. It was also suggested that with respect to paying for long-term care, there could be a medium ground between private-for-profit and public with respect to the amount that the individual pays and the amount that is subsidized by government. Also related to cost is the suggestion that there should be bulk purchasing for the entire system, which would lower costs. Some other concerns that were expressed include: 1) what will happen if private-for-profit operators run out of funds, 2) it was felt that the public system will not be able to compete with the comforts and surroundings that the private-for-profit system can offer, and 3) it was felt that the quality of care might decrease because private-for-profit facilities could try to hire staff as cheaply as possible so that they can save money. These concerns would certainly be lessened or laid to rest if sound provincial standards and monitoring mechanisms were developed.

It was the opinion of key informants that the pilot project has highlighted the fact that there is a need for provincial nursing home care standards, and for a great deal of long term planning for

long-term care. It was stated that standards and agreements should be developed to guarantee that equivalent quality care is provided at private-for-profit and public nursing homes. It was felt by key informants that the system needs to work harder at getting standards approved and put in place. It was also felt that there should not be any more pilot projects until a policy framework that covers high-level, long-term care has been developed. It was suggested that government should be able to dictate how many beds they will license per region, and that a cap should be put on the amount they are going to pay for care. Also, it was noted that the Provincial approach to long-term care should be proactive instead of reactive. Further, it was suggested that there needs to be a provincial monitoring system in place that is done officially and has some accountability mechanisms.

The majority of key informants indicated that the pilot project has had, and will have, implications for public perceptions regarding long-term care in this province. It was felt that public-private partnerships could help raise awareness in the public as to the importance of long-term care. However, it was also noted that the media attention to the project could have lowered the public's view of the long-term care system (especially since residents and family members were not aware that they were entering a pilot project). Further, it was felt that public expectations are greater now (e.g., people want single rooms) and that the project is challenging the province to provide better care. It was also noted that it could be difficult to convince families that the care at each facility is the same regardless of the structure or the accommodations. Still, it was felt that public-private partnerships would introduce more choice for clients. However, the opinion was given that the introduction of more choices will make it challenging to educate the public as to the types of long-term care available.

Conclusions and Recommendations of the Evaluators

This evaluation provides a wealth of information regarding various aspects of the CP pilot project along with quality and cost comparisons to SJNHB. As well, it provides a better understanding of the design and funding of long-term nursing care services in four other provinces. From the review of various current reports and studies on the topic of long-term nursing care, some of the significant factors that influence effective public-private partnership arrangements in this sector and the quality and cost of care have been discerned.

Based on the findings that have been presented throughout this report, the following recommendation around the continuance (or discontinuance) of this arrangement for nursing home care is provided:

> This evaluation indicates that this arrangement, namely the use of a public-private partnership arrangement similar to the CP pilot project, for the delivery of nursing home care can be continued.

Other recommendations regarding the pilot project include:

1. The following recommendations are made with regard to the monitoring of compliance to standards:
    a. The monitoring of the CP pilot project or other similar arrangements will necessitate better procedures and accountability mechanisms. Specifically, guidelines should be developed pertaining to the frequency of monitoring and the qualifications/objectivity of the monitoring agency.

b. A monitoring tool should be developed that ensures that all aspects of the agreement are covered.

c. The feasibility of developing a database to track improvements or instances of non-compliance over time should be assessed. This would better ensure that issues to be followed up on are assessed during subsequent monitoring stages.

d. Further exploration and inquiry are required at CP in terms of skill mix, infection rates, and medication errors.

2. While the information presented on resident quality of life and satisfaction with care may provide guidance as to service areas that could be improved at both facilities, policy or procedural changes should not be based on this information.
3. Explore the feasibility of further study regarding the impact of the nursing home subsidy provision on individuals' willingness to privately pay for accommodations at CP.
4. Roles/responsibilities of involved parties should be reviewed periodically and refinements made when misunderstandings occur.
5. Before the decision as to the future of the partnership is made public, the families should be briefed by professionals to prepare them for dealing with whatever direction the project takes.
6. If a public-private partnership such as that piloted at CP is continued, it is recommended that in addition to ongoing monitoring, a full evaluation be conducted at intervals agreed upon by involved parties.

Implications for the future

Based on the data collected for this evaluation and the findings that have been presented throughout this report, the implications for continuing with similar public-private partnership arrangements for nursing home care are presented as follows:

1. The provincial government would be expected to subsidize any similar arrangement; this will require that the government dedicate sufficient funds to meet this cost.
2. There are matters concerning how government funds similar arrangements in the future; two options are identified:

   a. Use of a standard funding formula that applies to all homes (e.g. Ontario model), or

   b. Use of an operating cost deficiency model that allows for different subsidies for different nursing homes (common to the three other provinces and Newfoundland and Labrador).

3. The Department of Health and Community Services and/or SJNHB may need to make it clear to those who ask that governments in the four provinces reviewed for this evaluation subsidize the operations of a nursing home and do not provide a subsidy to the individual as some believe. Individuals generally have a limited choice as to which home they enter which is independent of the subsidy arrangement.
4. In light of the different fees charged for nursing homes, there are several approaches to be considered for setting appropriate fees for nursing home residents under a public-private partnership arrangement:

   a. Use of a standard fee schedule with fees to cover all of the costs (CP model); this raises

the matter of the ability for residents to cover this cost

b. Use of a standard fee schedule with fees to cover specified components of the costs which makes the fee schedule relevant to residents' capacity to pay (e.g. Ontario model, and the Newfoundland and Labrador model in part)

c. Use of a variable fee schedule based on either the operating cost of a facility and/or ability to pay

5. The roles and responsibilities, including funding, of the Department of Health and Community Services and SJNHB (or another regional board in the province) in the negotiation and management of a similar arrangement with a private operator will have to be further refined. There is no definitive means to arrive at the appropriate relationship but it must be clarified and understood by the various stakeholders at the outset.
6. The current arrangement is managed through an agreement that also specifies standards and accountabilities. All of the four provinces reviewed for this evaluation have a mix of legislation, regulations, departmental policies, guidelines, agreements and other arrangements in place to "regulate" the operators of nursing homes. These measures apply to both for-profit and non-profit homes, generally. Government should consider soon if a legislated regime is necessary or if negotiated agreements for the provision and monitoring of nursing home care in the province are acceptable. Any legislated approach should be applicable to all operators (for-profit and non-profit operators and to include the province's institutional and integrated health care boards).
7. The provincial legislative, regulatory and departmental policy regimes and the funding mechanisms in place in the four select provinces to support the public-private partnership arrangements for the delivery of long-term nursing care are varied. However, these should be assessed further to identify best practices to form the basis of a comprehensive policy approach and funding regime for public-private partnership arrangements for this province.
8. As a party to public-private partnership arrangements, public agencies should not impose a higher standard than they themselves are able to meet; they should encourage innovation and flexibility so long as the overall objective of an acceptable level of resident care in a secure and comfortable environment is provided. The Department of Health and Community Services, with its partner agencies, can build on the lessons learned with the current pilot project arrangement to better define its requirements and compliance processes for any future similar arrangements.
9. A centralized entry system is viewed as an important component of access to long-term nursing care in the four provinces reviewed for this evaluation. This province has a recognized single-entry system; this system should be retained as the basis for any individual availing of a nursing bed funded under any future public-private partnership arrangements.
10. Finally, any future public-private partnership arrangement for nursing home care has to lend certainty to:

a. The individual resident (and family) who avails of the bed made available under the arrangement and who is concerned about movement between facilities at a fragile time in their lives,

b. The operator of the facility who has a significant financial and personal investment in the arrangement, and

c. The staff who work with the facility and seek assurance of job security.

The result of adhering to these requirements is that any future arrangement has to be of a long-term duration.

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Websites:

Ontario Association of Non-Profit Homes and Services for Seniors, http://www.oanhss.org.

The Canadian Council for Public-Private Partnerships, http://www.ppp.council.ca.

Appendix A

Summary of Evaluation Implementation Plan

Data to be collected	How will it be collected?	Who will collect it?	How often?
Compliance with standards including all aspects of care to be monitored as outlined in the agreement	- Using the agreement as a guide - Find out what tools are currently used	SJNHB	Yearly
Quality of Care	- Evidence for quality of care will come from compliance with standards reports, and satisfaction surveys	Evidence will come from a number of sources and will therefore be collected by various groups/individuals. Should be compiled and analyzed by the evaluation team	Every six months for satisfaction survey. Yearly for Compliance with standards. Analyzed yearly.
Resident QOL and satisfaction	- Client satisfaction survey	Administrative team at Chancellor Park. Must be anonymous and confidential	One month following admission to the facility (baseline) and every six months thereafter
Ongoing impacts and effectiveness of the agreement for involved parties (should include administrative impacts as well as issues related to such aspects as human resources, collective bargaining agreements, legislation, and policy)	- Key informant interviews with party representatives - Document review	Evaluation team	Yearly

Client profile and changes over time	- Using profiling tools used for the present evaluation to be completed by reviewing client records	CP administration will collect the data and provide it to the evaluation team for analysis	Analyzed yearly although collected on a continual basis
Staff compliment and hours of care over the course of the project	- Using tools/data collection practices already in place	CP administration – to be analyzed as a component of the compliance to standards monitoring as well as part of the yearly evaluation	Monthly
Cost effectiveness	- Key informant interviews - Document review	Evaluation team	Yearly
Impact of subsidy on willingness of others to privately pay for accommodations at CP	- An evaluation question to be asked of others at CP not involved in the project?	CP administration Evaluation team	Yearly
Financial Accountability at all levels	- Key informant interviews - Document review - Client interviews	Evaluation team	Yearly
Perception of residents and their families in other facilities around the addition of CP as a new option in the Single Entry System	Possibilities include: - Adding this question to others posed by HCSSJR during intake assessments - Posing this question to residents of CP not receiving nursing home subsidies - Asking for such information from a random sample of clients of the Single Entry System	* *Dependant upon method of data collection selected*	Analyzed yearly by evaluation team